

(BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

- (1) An individual who is a relative of an owner is a related party.
- (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
- (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.
- (4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:
 - (a) A supplier is a separate bona fide organization;
 - (b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;
 - (c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;
 - (d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.
- (5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").

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(CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:

- (1) Spouse;
- (2) Natural parent, child, or sibling;
- (3) Adopted parent, child, or sibling;
- (4) Step-parent, step-child, step-brother, or step-sister;
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
- (6) Grandparent or grandchild;
- (7) Foster parent, foster child, foster brother, or foster sister.

(DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (C) of this rule.

- (1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.
- (2) ODHS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODHS determines that the renovation is more prudent than construction of new beds.

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- (EE) "Nonextensive renovation" means the betterment, improvement, or restoration of a NF or ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (C) of this rule.
- (FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODHS under rule 5101:3-3-51 of the Administrative Code on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the rules of ODHS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODHS under rule 5101:3-3-51 of the Administrative Code, "construction is started" means the date in which the actual construction work begins at the facility site.
- (GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling set forth under rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code which corresponds to the period the beds were replaced.
- (HH) "RUG III" is the resource utilization groups, version III system of classifying nursing facility (NF) residents into case-mix groups described in rule 5101:3-3-41 of the Administrative Code.

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5101:3-3-02 Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

A "provider agreement" is a contract between the Ohio department of human services (ODHS) and a NF or an ICF-MR for the provision of NF services or ICF-MR services under the medicaid program. The provider's or authorized agent's signature binds the provider to the terms of the agreement.

In addition to provisions in rules 5101:3-3-021 and 5101:3-3-022 of the Administrative Code, execution and maintenance of a provider agreement between ODHS and a NF or ICF-MR is also contingent upon compliance with requirements set forth in this rule.

(A) The A NF or ICF-MR shall:

- (1) Execute the provider agreement in the format provided by ODHS.
- (2) Apply for and maintain a valid license to operate if required by law.
- (3) Comply with all applicable federal, state, and local laws and rules.
- (4) Keep records and file reports as required in rule 5101:3-3-20 [~~"Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"]~~ of the Administrative Code.
- (5) Open all records relating to the costs of its services for inspection and audit by ODHS and otherwise comply with rule 5101:3-3-20 of the Administrative Code.
- (6) Supply to ODHS such information as the department requires concerning NF or ICF-MR services to residents who are medicaid eligible or who have applied to be medicaid recipients.

"Medicaid eligible" means an individual has been determined eligible and has been issued an effective date of health care which covers the time period in question by a county department of human services (CDHS) under Chapter 5101:1-39 [~~"Medicaid eligibility requirements"]~~ of the Administrative Code.

- (7) Retain as a resident in the NF or ICF-MR any person who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in the NF or ICF-MR who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility, are considered residents in the NF or ICF-MR during any absence for which ~~leave~~ BED-HOLD days are reimbursed in ACCORDANCE WITH rules 5101:3-3-59 and 5101:3-3-92 of the Administrative Code.

- (8) Admit, as a resident in the NF or ICF-MR, a person who is medicaid eligible, whose application for medicaid is pending, or who is eligible for both medicare and medicaid, and whose level of care determination is appropriate for the admitting facility. This applies only if less than eighty per cent of the total residents in the NF or ICF-MR are recipients of medicaid. This provision does not require that any such resident be admitted if the individual requires a level of care or range of services that the NF or ICF-MR is not certified or otherwise qualified to provide.

(a) ~~Each participating NF or ICF-MR must report the following information in its monthly request for reimbursement to the CDHS:~~

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JOINT COMMITTEE
ON AGENCY RULE REVIEW

- (i) ~~The total number of NF or ICF-MR beds licensed by the Ohio department of health (ODH) under section 3721.02 of the Revised Code and/or the total number of beds licensed by the Ohio department of mental retardation and developmental disabilities (ODMR-DD) under section 5123.19 of the Revised Code, as well as the total number of medicaid-certified beds pursuant to Title XIX. County homes and other NFs or ICFs-MR not subject to licensure are to report the total certified capacity of the facility; and~~
- (ii) ~~The total number of residents, and subtotal number of residents broken down by payer type, occupying medicaid-certified beds identified in paragraph (A)(8)(a)(i) of this rule; and~~
- (iii) ~~The total number of residents whose application for medicaid is pending and who occupy beds identified in paragraph (A)(8)(a)(i) of this rule. Residents whose care is covered under a medicare benefit are not to be included; and~~
- (iv) ~~The total number of resident days, including medicaid leave days, in available beds identified in paragraph (A)(8)(a)(i) of this rule. NF leave days are counted as half resident days; ICF-MR leave days are counted as full resident days; and~~
- (v) ~~The total number of resident days for recipients of medicaid, including medicaid leave days, in available beds identified in paragraph (A)(8)(a)(i) of this rule; and~~
- (vi) ~~The total number of pending recipients and the total number of medicaid recipients who requested but were denied admission during the month, and the reasons for their denial.~~

(b) (a) In order to comply with these provisions, the NF or ICF-MR admission policy shall be designed to admit residents sequentially based on the following:

- (i) The requested admission date; and
- (ii) The date and time of receipt of the request; and
- (iii) The availability of the level of care or range of services necessary to meet the needs of the applicants; AND
- (iv) GENDER: SHARING A ROOM WITH A RESIDENT OF THE SAME SEX (EXCEPT MARRIED COUPLES WHO AGREE TO SHARE THE SAME ROOM.)

(e)(b) The NF or ICF-MR shall maintain a written list of all requests for each admission. The list shall include the name of the potential resident; date and time the request was received; the requested admission date; and the reason for denial if not admitted. This list shall be made available upon request to the staff of ODHS, CDHS, and ODH.

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(d)(c) The following are exceptions to paragraph (A)(8) of this rule:

- (i) Medicaid eligible residents of NFs who are on hospital stays; visiting with family and friends; or participating in therapeutic programs; and have exhausted coverage for ~~leave~~ BED-HOLD days under rule 5101:3-3-59 of the Administrative Code, must be readmitted to the first available semi-private bed IN ACCORDANCE WITH THE PROVISIONS OF RULE 5101:3-3-59 OF THE THE ADMINISTRATIVE CODE; or
- (ii) Any county home organized under Chapter 5155. of the Revised Code may admit residents exclusively from the county in which the county home is located; or
- (iii) Any religious or denominational NF or ICF-MR that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination; or
- (iv) A NF may give preference to persons with whom it has contracted to provide continuing care.

"Continuing care" refers to the living setting which provides the resident with an apartment or lodging; meals; maintenance services; and when necessary, nursing home care. All services are provided on the premises of the continuing care community. The resident signs a contract which identifies the continuum of services to be covered by the resident's initial entrance fee and subsequent monthly charges. If a continuing care contract provides for a living arrangement which specifically states that all health care services including nursing home services are met in full, medicaid payment cannot be made for those services covered by the contract. If a continuing care contract provides for only a portion of the resident's health care services, that portion shall be deducted from the actual cost of nursing home care and medicaid shall recognize the difference up to the medicaid maximum per diem.

- (v) A NF or ICF-MR may decline to admit a medicaid applicant if that facility has a resident whose application was pending upon admission and has been pending for more than sixty days, as verified by the CDHS. The NF or ICF-MR shall submit the necessary documentation in a timely manner as required in rules 5101:3-3-151 and 5101:3-3-153 of the Administrative Code.

(9) ~~A NF must provide a statement to the resident explaining the resident's obligation to reimburse the cost of care provided during the application process, if it is not covered by medicaid.~~

EFFECTIVE JULY 1, 1997 AND THEREAFTER, PROVIDE THE FOLLOWING NECESSARY INFORMATION TO ODHS AND CDHS TO PROCESS RECORDS FOR PAYMENT AND ADJUSTMENT:

- (a) SUBMIT THE "FACILITY/CDHS TRANSMITTAL" (ODHS 9401) TO THE CDHS TO INFORM THE CDHS OF ANY INFORMATION REGARDING A SPECIFIC RESIDENT FOR MAINTENANCE OF CURRENT AND ACCURATE PAYMENT RECORDS AT THE CDHS AND THE FACILITY; AND

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(b) SUBMIT THE "FACILITY PAYMENT AND ADJUSTMENT AUTHORIZATION" (ODHS 9400) DIRECTLY TO ODHS TO INITIATE, TERMINATE OR ADJUST VENDOR PAYMENT ON A SPECIFIC RESIDENT AS REQUIRED.

(10) ~~Not require a third party to accept personal responsibility for paying the facility charges out of his or her own funds. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources if the resident's medicaid application is denied and if the resident's cost of care is not being paid by medicare or other third party payor. A third party guarantee is not the same as a third party payor (i.e., an insurance company), and this provision does not preclude the facility from obtaining information about medicare and medicaid eligibility or the availability of private insurance. The prohibition against third party guarantees applies to all residents and prospective residents in all certified NFs or ICFs-MR regardless of payment source. Notwithstanding the above, this provision does not prohibit a third party from voluntarily making payment on behalf of a resident.~~

(+1) (10) Permit access to facility and records for inspection by ODHS, ODH, CDHS, REPRESENTATIVES OF THE OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.

(+2) (11) In the case of a change of provider agreement as defined in rules 5101:3-3-516 and 5101:3-3-845 of the Administrative Code, or dissolution of a business, follow the procedures in paragraphs ~~(A)(12)(a)~~ (A)(11)(a) to ~~(A)(12)(e)~~ (A)(11)(c) of this rule.

(a) The current provider ~~(seller)~~ must provide a written notice to ODHS, as provided in rules 5101:3-3-516 and 5101:3-3-845 of the Administrative Code, at least forty-five days prior to the effective date of any contract of sale OR NEW LEASE AGREEMENT for the NF or ICF-MR.

(b) The ~~seller~~ PROVIDER must submit documentation of any transaction (i.e., sales agreement, contract or lease) as requested by ODHS to determine whether a change of provider has occurred as specified in rules 5101:3-3-516 and 5101:3-3-845 of the Administrative Code.

(c) The new provider ~~(purchaser)~~, upon acceptance of ~~assignment of the~~ A NEW provider agreement, shall submit an application for participation in the medicaid program and a written statement of intent to abide by ODHS rules, the provisions of the ~~assigned~~ NEW provider agreement; and any existing statement of deficiencies and plan of correction (HCFA 2567) submitted by the previous provider.

(13) ~~A NF shall comply with the requirements in paragraph (E) of rule 5101:3-3-041 of the Administrative Code, and repay ODHS the federal share of payments under the circumstances required by sections 5111.45 and 5111.58 of the Revised Code.~~

(+4) (12) Assure the security of all personal funds of residents in accordance with rules 5101:3-3-60 and 5101:3-3-93 of the Administrative Code.

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(15) (13) Terminate the provider agreement by providing ODHS; the resident, or guardian; and the residents' sponsors; a written notice at least ninety days prior to the termination. A NF OR ICF-MR THAT DOES NOT ISSUE THE PROPER NOTICE IS SUBJECT TO THE PENALTIES SPECIFIED IN RULES 5101: 3-3-516 AND 5101:3-3-845 OF THE ADMINISTRATIVE CODE.

(16) (14) Comply with Title VI and Title VII of the Civil Rights Act of 1964 and Public Law 101-336 (the Americans with Disabilities Act of 1990), and shall not discriminate against any resident on the basis of race; , color; , age; , sex; , creed; , national origin; , or disability.

(15) PROVIDE TO ODHS , THROUGH THE COURT OF JURISDICTION, NOTICE OF ANY ACTION BROUGHT BY PROVIDER IN ACCORDANCE WITH TITLE 11 OF THE UNITED STATES CODE (BANKRUPTCY). NOTICE SHALL BE MAILED TO: "OFFICE OF LEGAL SERVICES, OHIO DEPARTMENT OF HUMAN SERVICES, 30 EAST BROAD STREET-31ST. FLOOR, COLUMBUS, OHIO 43215."

(B) A NF SHALL:

(1) PROVIDE A STATEMENT TO THE RESIDENT EXPLAINING THE RESIDENT'S OBLIGATION TO REIMBURSE THE COST OF CARE PROVIDED DURING THE APPLICATION PROCESS, IF IT IS NOT COVERED BY MEDICAID.

(2) COMPLY WITH THE REQUIREMENTS IN PARAGRAPH (F) OF RULE 5101:3-3-041 OF THE ADMINISTRATIVE CODE AND REPAY ODHS THE FEDERAL SHARE OF PAYMENTS UNDER THE CIRCUMSTANCES REQUIRED BY SECTIONS 5111.45 AND 5111.58 OF THE REVISED CODE.

(B) (C) A NF or ICF-MR ~~may not charge fees for the application process of a medicaid resident or applicant.~~ SHALL NOT:

(1) CHARGE FEES FOR THE APPLICATION PROCESS OF A MEDICAID RESIDENT OR APPLICANT.

(2) CHARGE A MEDICAID RESIDENT AN ADMISSION FEE.

(3) CHARGE A MEDICAID RESIDENT AN ADVANCE DEPOSIT.

(4) REQUIRE A THIRD PARTY TO ACCEPT PERSONAL RESPONSIBILITY FOR PAYING THE FACILITY CHARGES OUT OF HIS OR HER OWN FUNDS. HOWEVER, THE FACILITY MAY REQUIRE AN INDIVIDUAL WHO HAS LEGAL ACCESS TO A RESIDENT'S INCOME OR RESOURCES AVAILABLE TO PAY FOR FACILITY CARE TO SIGN A CONTRACT, WITHOUT INCURRING PERSONAL FINANCIAL LIABILITY, TO PROVIDE FACILITY PAYMENT FROM THE RESIDENT'S INCOME OR RESOURCES IF THE RESIDENT'S MEDICAID APPLICATION IS DENIED AND IF THE RESIDENT'S COST OF CARE IS NOT BEING PAID BY MEDICARE OR ANOTHER THIRD-PARTY PAYOR. A THIRD-PARTY GUARANTEE IS NOT THE SAME AS A THIRD-PARTY PAYOR (I.E, AN INSURANCE COMPANY), AND THIS PROVISION DOES NOT PRECLUDE THE FACILITY FROM OBTAINING INFORMATION ABOUT MEDICARE AND MEDICAID ELIGIBILITY OR THE AVAILABILITY OF PRIVATE INSURANCE. THE PROHIBITION AGAINST THIRD-PARTY GUARANTEES APPLIES TO ALL RESIDENTS AND PROSPECTIVE RESIDENTS IN ALL CERTIFIED NFS OR ICFS-MR REGARDLESS OF PAYMENT SOURCE.

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NOTWITHSTANDING THE ABOVE, THIS PROVISION DOES NOT PROHIBIT A THIRD PARTY FROM VOLUNTARILY MAKING PAYMENT ON BEHALF OF A RESIDENT.

~~(C) The NF or ICF-MR may not charge a resident an admission fee.~~

~~(D) A NF or ICF-MR may not charge a resident an advance deposit.~~

~~(E)~~ (D) ODHS shall:

(1) Execute a provider agreement in accordance with the certification provisions set forth by the secretary of health and human services and ODH.

(2) In the case of a change of provider agreement, ~~assign the~~ **ISSUE A NEW** provider agreement to the new provider contingent upon the new provider's compliance with paragraph ~~(A)(12)(e)~~ **(A)(11)(c)** of this rule.

(3) Provide copies of ODHS rules governing the facility's participation as a provider in the medical assistance program. Whenever ODHS files a proposed rule; or proposed rule in revised form under division (D) of section 111.15, or division (B) of section 119.03 of the Revised Code; the department shall provide the facility with one copy of such rule. In the case of a rescission or proposed rescission of a rule, ODHS may provide the rule number and title instead of the rules rescinded or proposed to be rescinded.

(4) Make payments in accordance with Chapter 5111. of the Revised Code and Chapter 5101:3-3 of the Administrative Code to the NF or ICF-MR for services to residents eligible **AND APPROVED FOR VENDOR PAYMENT** under the medicaid program. Payments shall be made no later than the fifteenth day of the month following the month in which care and services are provided to residents, with the following exceptions:

(a) Payment shall be made no later than the fifteenth day of the second calendar month following: the month in which a resident was determined to be eligible; or the month the resident's medicare benefit has exhausted. Notification must be submitted to the CDHS during the month in which eligibility is determined, or in the month medicare benefits are exhausted. ~~Payment will be made retroactive to the date of admission; the resident's effective date of health care; or the day following the exhaustion of medicare benefits; whichever is later.~~ **THE EFFECTIVE DATE OF AUTHORIZATION FOR PAYMENT SHALL BE MADE IN ACCORDANCE WITH RULES 5101: 3-3-15, 5101: 3-3-151, 5101:3-3-152 AND 5101:3-3-153 OF THE ADMINISTRATIVE CODE.**

(b) The first payment shall be made no later than sixty days following the date of authorized admission.

~~An "authorized admission" is an admission of an individual determined to be medicaid eligible prior to admission.~~

~~(c) Payment will be made retroactive to the day of admission.~~

~~(F)~~ **(E)** ODHS may terminate, suspend, not enter into, or not renew, the provider agreement upon thirty days written notice to the provider for violations of Chapter 5111. of the Revised Code; Chapters 5101:3-1 and 5101:3-3 of the Administrative Code; and if applicable, subject to Chapter 119. of the Revised Code.

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