

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

In addition to provisions in rules 5101:3-3-02.1 and 5101:3-3-02.2 of the Administrative Code, execution and maintenance of a provider agreement between the Ohio department of job and family services (ODJFS) and the operator of a NF or ICF-MR is also contingent upon compliance with requirements set forth in this rule.

(A) Definitions.

- (1) "Closure" means the discontinuance of the use of the building or part of the building that houses the facility as a NF or ICF-MR, and that results in the relocation of the facility's residents who continue to require NF or ICF-MR services. If the building is converted to a different use and acquires a new type of license, residents who require services offered under the new license type may remain.
  - (a) A facility's closure occurs regardless of whether there is a replacement of the facility; whereby the operator completely or partially replaces the facility's physical plant through the construction of a new physical plant or the transfer of the facility's license from one physical plant location to another.
  - (b) Facility closure ~~also~~ occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another NF or ICF-MR.
  - (c) A facility closure ~~also~~ occurs regardless of action taken by the Ohio department of health (ODH) related to the facility's certification under Title XIX of the Social Security Act, 79 stat. 286 (1965), 42 U.S.C.A. 1396, (~~as amended through April 15, 2003~~), that may result in the transfer of part of the facility's survey findings to a replacement facility, or related to retention of a license as a NF under Chapter 3721. of the Revised Code or as a residential facility under Chapter 5123. of the Revised Code.
  - (d) The last effective date of the provider agreement of a closed facility will be the date of the relocation of the last resident.
- (2) "Continuing care" refers to the living setting ~~which~~ that provides the individual with different types of care based on a resident's need over time and may include 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 individual signs a contract ~~which~~ that identifies the continuum of services to be covered by the individual's initial entrance fee and subsequent monthly charges. If a continuing care contract provides for a living arrangement ~~which~~ that 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~~ pay the difference up to the medicaid maximum per diem. An individual who entered into a life care or continuing care contract may be eligible for medicaid ~~after a continuing care contract was signed~~ under the conditions in rule ~~5101:1-39-46~~ 5101:1-39-02.2 of the Administrative Code.

- (3) "Failure to pay" means that an individual ~~has a medicaid application in pending status and~~ has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the individual's behalf, for the care provided by the NF or ICF-MR. An individual shall be considered to have failed to have the individual's care paid for ~~if~~ when the individual has ~~applied for medicaid~~ a medicaid application in pending status, if both of the following are the case:
- (a) The individual's application, or a substantially similar previous application, has been denied by the county department of job and family services (CDJFS); and
  - (b) If the individual appealed the denial pursuant to division (C) of section 5101.35 of the Revised Code, ~~and~~ the director of ODJFS upheld the denial.
- (4) "Medicaid eligible" means an individual has been determined eligible by the CDJFS under Chapter 5101:1-39 of the Administrative Code and has been issued an effective date of health care ~~which covers coverage for~~ the time period in question ~~by the CDJFS under Chapter 5101:1-39 of the Administrative Code~~.
- (5) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates a NF or ICF-MR.
- (6) "Voluntary withdrawal" means that the operator of a NF, in compliance with section 1919(c)(2)(F) of the Social Security Act ~~(as amended through April 15, 2003)~~, voluntarily elects to withdraw from participation in the medicaid program but chooses to continue providing services of the type provided by

NFs. For ICFs-MR "voluntary withdrawal" means the operator elects to voluntarily terminate from the medicaid program.

(B) A provider of a NF or ICF-MR shall:

- (1) Execute the provider agreement in the format provided by ODJFS; and
- (2) Apply for and maintain a valid license to operate if required by law; and
- (3) Comply with the provider agreement and all applicable federal, state, and local laws and rules; and
- (4) Keep records and file reports as required in rule 5101:3-3-20 of the Administrative Code; and
- (5) Open all records relating to the costs of its services for inspection and audit by ODJFS and otherwise comply with rule 5101:3-3-20 of the Administrative Code; and
- (6) Supply to ODJFS such information as the department requires concerning NF or ICF-MR services to individuals who are medicaid eligible or who have applied to be medicaid recipients; and
- (7) Unless the conditions described in paragraph (J) of this rule are applicable, retain as a resident in the NF or ICF-MR any individual 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 bed-hold days are reimbursed in accordance with rules ~~5101:3-3-59~~ 5101:3-3-16.4 and ~~5101:3-3-92~~ 5101:3-3-16.8 of the Administrative Code; and
- (8) Unless the conditions described in paragraph (J) of this rule are applicable, admit as a resident in the NF or ICF-MR, an individual 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.
  - (a) In order to comply with these provisions, the NF or ICF-MR admission policy shall be designed to admit individuals 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.)
- (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 ODJFS, CDJFS, and ~~the Ohio department of health (ODH)~~ ODH.
- (c) The following are exceptions to paragraph (B)(8) of this rule:
- (i) Bed-hold days are exhausted.
 

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 bed-hold days under rule ~~5101:3-3-59~~ 5101:3-3-16.4 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~~ 5101:3-3-16.4 of the Administrative Code; or
  - (ii) Facility is a county home.
 

Any county home organized under Chapter 5155. of the Revised Code may admit individuals exclusively from the county in which the county home is located; or
  - (iii) Facility has a religious sponsor.
 

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) NF has continuing care contracts.

A NF may give preference to ~~persons~~ individuals with whom it has contracted to provide continuing care.

(v) Prolonged "medicaid pending" application status.

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 CDJFS. The NF or ICF-MR shall submit the necessary documentation in a timely manner as required in rules 5101:3-3-15.1 and 5101:3-3-15.3 of the Administrative Code.

(9) ~~Effective July 1, 1997 and thereafter, provide~~ Provide the following necessary information to ODJFS and CDJFS to process records for payment and adjustment:

(a) Submit the "~~facility/CDJFS transmittal~~" JFS 09401 "Facility/CDJFS Transmittal" (~~JFS 09401, rev. 5/2001~~4/2007) to the CDJFS to inform the CDJFS of any information regarding a specific resident for maintenance of current and accurate ~~payment~~ records at the CDJFS and the facility; and

(b) For dates of service prior to July 1, 2005, submit the "~~nursing facility payment and adjustment authorization~~" JFS 09400 "Nursing Facility Payment and Adjustment Authorization" (~~JFS 09400, rev. 12/2001~~) directly to ODJFS to initiate, terminate, or adjust ~~vendor~~ medicaid payment ~~on~~ for a specific resident as required.

(c) For dates of service on or after July 1, 2005:

(i) An ICF-MR shall submit the "~~nursing facility payment and adjustment authorization~~" (~~JFS 09400, rev. 12/2001~~) directly to ODJFS to initiate, terminate, or adjust ~~vendor~~ medicaid payment ~~on~~ for a specific resident as required.

(ii) A NF shall submit an 837I transaction as required in rule 5101:3-3-39.1 of the Administrative Code to ODJFS to initiate, terminate, or adjust medicaid payment ~~on~~ for a specific resident.

(10) Permit access to facility and records for inspection by ODJFS, ODH, CDJFS,

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.

- (11) In the case of a change of ~~provider agreement~~ operator as defined in ~~rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative section 5111.65 of the Revised Code, or dissolution of a business,~~ follow the procedures in paragraphs (B)(11)(a) to (B)(11)(~~ed~~) of this rule.
- (a) The exiting ~~provider~~ operator or owner and entering operator must provide a written notice to ODJFS, as provided in ~~rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative section 5111.67 of the Revised Code, at least forty-five days prior to the effective date of any ~~contract of sale or new lease agreement actions that constitute a change of operator~~ for the NF or ICF-MR, but at least ninety days if residents are to be relocated. An exiting operator that does not give proper notice is subject to the penalties specified in section 5111.28 of the Revised Code.~~
- (b) The ~~provider~~ entering operator must submit documentation of any transaction (~~i.e.e.g.~~, sales agreement, contract, or lease) as requested by ODJFS to determine whether a change of ~~provider~~ operator has occurred as specified in ~~rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative section 5111.67 of the Revised Code.~~
- (c) The entering operator shall submit an application for participation in the medicaid program and a written statement of intent to abide by ODJFS rules, the provisions of the ~~new assigned~~ provider agreement, and any existing ~~statement of deficiencies and plan of correction (CMS 2567; "Statement of Deficiencies and Plan of Correction" (rev. 2/1999); statement of deficiencies and plan of correction,~~ submitted by the ~~previous provider~~ exiting operator.
- (d) An entering operator is subject to the same survey findings as the exiting operator unless the entering operator does not accept assignment of the exiting operator's provider agreement. Refusal to accept assignment results in termination of certification on the last day of the exiting operator's participation in medicaid. An entering operator who refuses assignment may reapply for medicaid participation and must undergo a complete initial certification survey by ODH. There may be gaps in medicaid coverage at the facility.
- (12) ~~Assure~~ Ensure the security of all personal funds of residents in accordance with rules ~~5101:3-3-60~~ 5101:3-3-16.5 and ~~5101:3-3-93~~ 5101:3-3-16.9 of the

Administrative Code.

- (13) Comply with Title VI and Title VII of the Civil Rights Act of 1964 (~~as amended through April 15, 2003~~) and Public Law 101-336 (the Americans with Disabilities Act of 1990, ~~as amended through April 15, 2003~~), and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.
- (14) Provide notice to ODJFS, ~~through the court of jurisdiction, notice within thirty days of any action brought by the provider in accordance with Title 11 of the United States Code (bankruptcy, as amended through April 15, 2003)~~ bankruptcy or receivership pertaining to the provider. Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street-31st. Floor, Columbus, Ohio 43215-3414;" and to: "Office of the Attorney General, 150 East Gay Street, 21st Floor, Columbus, Ohio 43215."

(C) A provider of a NF shall:

- (1) Provide a statement to the individual explaining the individual's obligation to reimburse the cost of care provided during the medicaid application process; if it is not covered by medicaid.
- (2) Comply with the requirements in ~~paragraph (F) of~~ rule 5101:3-3-04.1 of the Administrative Code and repay ODJFS the federal share of payments under the circumstances required by sections 5111.45 and 5111.58 of the Revised Code.
- (3) During a closure or voluntary withdrawal from the medicaid program provide ODJFS, the resident or guardian, and the residents' sponsors a written notice ~~of~~ at least ninety days prior to the closure or voluntary withdrawal. A NF that does not issue the proper notice is subject to the penalties specified in ~~rule 5101:3-3-51.6 of the Administrative~~ section 5111.28 of the Revised Code.
- (4) Comply with the following requirements when voluntarily withdrawing from the medicaid program:
- (a) Continue to provide NF services to residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day).
- (i) A NF operator's voluntary withdrawal from participation in the

medicaid program is not an acceptable basis for the transfer or discharge of these residents.

(ii) Nothing in this provision invalidates other legal grounds for NF-initiated discharge of medicaid residents after the effective date of withdrawal.

(b) Provide residents admitted after the effective date of withdrawal with information that the facility is not participating in the medicaid program with respect to those residents.

(c) Provide notice to ODJFS within fourteen days after the last medicaid funded resident has been relocated.

(D) A provider of an ICF-MR shall:

~~During a "closure" or "voluntary withdrawal" from the medicaid program provide~~ Provide ODJFS; the resident or guardian, and the residents' sponsors; a written notice at least ninety days prior to ~~the a "closure" or "voluntary withdrawal" from the medicaid program.~~ An ICF-MR that does not issue the proper notice is subject to the penalties specified in ~~rule 5101:3-3-84.5 of the Administrative section 5111.28 of the Revised Code.~~

(E) A provider of a NF or ICF-MR shall not:

- (1) Charge fees for the application process of a medicaid individual or applicant.
- (2) Charge a medicaid individual an admission fee.
- (3) Charge a medicaid individual an advance deposit. However, a NF may charge an individual whose medicaid eligibility is pending, typically in the form of a pre-admission deposit or payment for services after admission. A NF that has charged a resident for services between the first month of eligibility established by the state and the date notice of eligibility is received is obligated to refund any payments received for that period less the state's determination of any resident's share of the NF costs for that same period.
- (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 a representative who has legal access to ~~an~~ individual'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 individual's income or resources if the individual's medicaid application is denied and if the individual'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 individuals and prospective individuals in all certified NFs or ICFs-MR regardless of payment source. ~~Notwithstanding the above, this~~ This provision does not prohibit a third party from voluntarily making payment on behalf of an individual.

(F) ODJFS 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 operator, issue ~~a new~~ an assigned provider agreement to the entering operator contingent upon the entering operator's compliance with paragraph (B)(11)(c) of this rule.
  - (3) Whenever ODJFS 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, ODJFS shall notify affected persons by posting on the ODJFS website the full text of rules governing the facility's participation as a medicaid provider. ODJFS may also send an email notice of the rule action to all persons whose name or contact information appears on a distribution list maintained by ODJFS. Persons may voluntarily submit an email address on an ODJFS maintained website in order to receive electronic communications regarding proposed rule actions. ODJFS shall maintain the electronic distribution list; however, the sole responsibility of the validity of any email address maintained on the distribution list is that of the person who submitted the email address.
  - (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 individuals eligible and approved for ~~vendor~~ payment under the medicaid program.
- (G) ODJFS 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.
- (H) Any NF or ICF-MR violating provisions defined in paragraphs (B)(7) and (B)(8) of this rule will be subject to a penalty in accordance with provisions of section

5111.99 of the Revised Code.

- (I) The CDJFS shall use the ~~"facility/CDJFS transmittal" (JFS 09401) to inform the~~ communicate with NFs and ICFs-MR of any information regarding a ~~specific individual necessary for maintenance of current and accurate payment records at the CDJFS and the facility~~ the assessment of payment for specific individuals.

(J) Exclusions.

The provisions of paragraphs (B)(7) and (B)(8) of this rule do not require an individual to be admitted or retained at the NF or ICF-MR if the individual meets one of the following:

- (1) 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; or
- (2) The individual has a medicaid application in pending status and meets the definition of "failure to pay" in this rule.

Effective:

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Certification

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Date

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