

TO BE RESCINDED

5123:2-7-02

Intermediate care facilities - provider agreements.

(A) For the purposes of this rule, the following definitions shall apply:

- (1) "Closure" means the discontinuance of the use of the building or part of the building that houses the intermediate care facility, and that results in the relocation of the facility's residents who continue to require intermediate care facility services.
 - (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 occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another intermediate care facility.
 - (c) A facility closure occurs regardless of action taken by the Ohio department of health related to the facility's certification under Title XIX of the Social Security Act, 79 stat. 286 (1965), 42 U.S.C. 1396, 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 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) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates an intermediate care facility.
- (3) "Reasonable assurance period" means a certain period of time, determined by the centers for medicare and medicaid services, for which a long-term care facility operator whose provider agreement has been involuntarily terminated is required to operate without recurrence of the deficiencies that were the basis for termination. Participation in the medicare and medicaid programs may resume only following that period. If corrections were made before submission of a new request for participation, the period of compliance before the new request is counted as part of the period.

- (4) "Voluntary withdrawal" means the operator elects to voluntarily terminate from the medicaid program.
- (B) Each intermediate care facility shall have a medicaid provider agreement with the Ohio office of medical assistance. Execution and maintenance of a provider agreement between the Ohio office of medical assistance and the operator of an intermediate care facility is also contingent upon compliance with requirements set forth in this rule.
- (C) An intermediate care facility shall:
- (1) Execute the provider agreement in the format provided by the Ohio office of medical assistance.
 - (2) Apply for and maintain a valid license to operate.
 - (3) Comply with the provider agreement and all applicable federal, state, and local laws and rules.
 - (4) Keep records and file cost reports as required by rule 5123:2-7-12 of the Administrative Code.
 - (5) Open all records relating to the costs of its services for inspection and audit by the department and the Ohio office of medical assistance and otherwise comply with rule 5123:2-7-12 of the Administrative Code.
 - (6) Supply to the department and the Ohio office of medical assistance such information as the department or the Ohio office of medical assistance requires concerning services to individuals who have applied for or been determined to be eligible for medicaid.
 - (7) Provide the following necessary information to process records for payment and adjustment:
 - (a) Submit Ohio office of medical assistance form 09401, "Facility CDJFS Transmittal" (revised April 2011), to the county department of job and family services for any information regarding a specific resident for maintenance of current and accurate records; and
 - (b) Submit Ohio office of medical assistance form 09400, "Nursing Facility Payment and Adjustment Authorization" (revised October 2012), to the Ohio office of medical assistance to initiate, terminate, or adjust medicaid payment for a specific resident as required.

- (8) Permit access to the facility and its records for inspection by the department, the Ohio office of medical assistance, the Ohio department of health, the county department of job and family services, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.
- (9) In the case of a change of operator as defined in section 5111.65 of the Revised Code, adhere to the following procedures.
- (a) The exiting operator or owner and entering operator must provide a written notice to the department and the Ohio office of medical assistance, as provided in section 5111.67 of the Revised Code, at least forty-five days prior to the effective date of any actions that constitute a change of operator for the intermediate care facility, 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 entering operator must submit documentation of any transaction (e.g., sales agreement, contract, or lease) as requested by the department or the Ohio office of medical assistance to determine whether a change of operator has occurred as specified in 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 rules of the department and the Ohio office of medical assistance, the provisions of the assigned provider agreement, and any existing centers for medicare and medicaid services form CMS-2567, "Statement of Deficiencies and Plan of Correction" (revised February 1999), submitted by the 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 the Ohio department of health. There may be gaps in medicaid coverage at the facility.
- (10) Comply with Title VI of the Civil Rights Act, 42 U.S.C. 2000d (1964), Title VII of the Civil Rights Act, 42 U.S.C. 2000e (1991), and Public Law 101-336 (the Americans with Disabilities Act of 1990), 42 U.S.C. 12101 (2008), and shall

not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.

- (11) Provide notice to the department within five days of any bankruptcy or receivership pertaining to the provider. All requests shall be in writing and shall be mailed to "Ohio Department of Developmental Disabilities, Division of Medicaid Development and Administration, 30 East Broad Street, 13th Floor, Columbus, Ohio 43215-3414" or faxed to (614) 466-0652.
- (12) Provide the department, the Ohio office of medical assistance, the resident or guardian, and anyone designated by the resident or guardian written notice at least ninety days prior to a closure or voluntary withdrawal from the medicaid program. An intermediate care facility that does not issue the proper notice is subject to the penalties specified in section 5111.28 of the Revised Code.

(D) An intermediate care facility 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.
- (4) Directly bill its residents for or directly pass through to its residents the franchise permit fee.
- (5) 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 intermediate care facilities regardless of payment source. This provision does not prohibit a third party from voluntarily making payment on behalf of an individual.

(E) Effective dates of provider agreements

- (1) Effective dates of initial provider agreements generally are assigned by the state survey agency on the basis of findings of compliance or substantial compliance with standards of certification.
- (2) If a provider agreement is involuntarily terminated by the centers for medicare and medicaid services as the result of a look behind survey, re-entry into the medicaid program requires satisfaction of the reasonable assurance period as set forth in the "Medicaid State Operations Manual," chapter 2, section 2016F (October 1, 2010).

(F) Conditional provider agreements and cancellation clauses

- (1) If the state survey agency determines that an intermediate care facility is in substantial compliance with medicaid standards but has deficiencies that must be corrected, the Ohio office of medical assistance may execute a conditional provider agreement for a term of up to twelve full calendar months, subject to an automatic cancellation clause.
- (2) The intermediate care facility must correct deficiencies within sixty days following the scheduled date of correction as established by the state survey agency.
- (3) If deficiencies are corrected before the cancellation date, the state survey agency may rescind the cancellation notice, and shall notify the department and the Ohio office of medical assistance in writing of its decision.
- (4) If deficiencies are not corrected before the cancellation date, the state survey agency may propose termination of the provider agreement.
- (5) If deficiencies are not corrected, the Ohio office of medical assistance may cancel the provider agreement in accordance with section 5111.06 of the Revised Code, unless one of the following occurs:
 - (a) The state survey agency finds that all required corrections have been made and notifies the department and the Ohio office of medical assistance; or
 - (b) The state survey agency determines that substantial progress has been made in carrying out a plan of correction that has been submitted to and accepted by the state survey agency.

- (G) At the request of the department or upon its own initiative, the Ohio office of medical assistance may terminate, suspend, or not enter into the provider agreement upon thirty days written notice to the provider for violations of Chapter 5111. of the Revised

Code; Chapters 5101:3-1, 5101:3-3, and 5123:2-7 of the Administrative Code; and if applicable, subject to Chapter 119. of the Revised Code.

- (1) In accordance with section 5111.22 of the Revised Code, a provider agreement may be terminated, denied, or not renewed if the Ohio office of medical assistance determines such an agreement is not in the best interests of the state or medicaid recipients. Best interests include, but are not limited to:
 - (a) The provider has not fully and accurately disclosed information as required by the provider agreement or any rule contained in division 5101:3 or 5123:2 of the Administrative Code;
 - (b) The provider has failed to abide by or to have the capacity to comply with the terms and conditions of the provider agreement and/or rules and regulations promulgated by the department or the Ohio office of medical assistance;
 - (c) The provider has been found liable by a court for negligent performance of professional duties;
 - (d) The provider has failed to file cost reports as required by rule 5123:2-7-12 of the Administrative Code;
 - (e) The provider has made false statements or has altered records, documents, or charts. Alteration does not include properly documented correction of records;
 - (f) The provider has failed to cooperate or provide requested records or documentation for purposes of an audit or review of any provider activity by any federal, state, or local agency;
 - (g) The provider has been found in violation of section 504 of the Rehabilitation Act of 1973, the Civil Rights Act of 1964, or Public Law 101-336 (the Americans with Disabilities Act of 1990) in relation to the employment of individuals, the provision of services, or the purchase of goods and services;
 - (h) The attorney general, auditor of state, or any board, bureau, commission, or agency has recommended termination of the provider agreement where the reason for the request bears a reasonable relationship to the administration of the medicaid program or the integrity of state and/or federal funds;

- (i) The provider has violated the prohibition against billing medicaid residents for covered services or factoring as found in rule 5101:3-1-13.1 or 5101:3-1-23 of the Administrative Code;
 - (j) The facility has been found by the Ohio department of health during a survey of the facility to have an emergency that is the result of a determination that there is noncompliance at the condition of participation level that constitutes immediate jeopardy; and
 - (k) The provider fails to pay the full amount of a franchise permit fee pursuant to section 5112.341 of the Revised Code.
- (2) The Ohio office of medical assistance shall terminate, deny, or not renew a provider agreement when any of the situations set forth in division (D) of section 5111.06 of the Revised Code occur.
- (3) Notices and termination orders shall comply with provisions set forth in section 5111.06 of the Revised Code.
- (H) The county department of job and family services shall use the Ohio office of medical assistance form 09401, "Facility CDJFS Transmittal" (revised April 2011), to communicate information regarding a specific individual.

Effective: 12/16/2019

Five Year Review (FYR) Dates: 10/1/2019

CERTIFIED ELECTRONICALLY

Certification

12/06/2019

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02, 5111.226, 5123.04
Rule Amplifies: 5111.02, 5111.226, 5123.04
Prior Effective Dates: 01/10/2013