Ohio Administrative Code

Rule 5160-3-02 Nursing facilities (NFs): provider agreements.

Effective: June 24, 2016

In addition to provisions in Chapters 5164. and5165. of the Revised Code regarding provider agreements, and provisions inrules 5160-3-02.1 and 5160-3-02.2 of the Administrative Code, execution andmaintenance of a provider agreement between the Ohio department of medicaid(ODM) and the operator of a NF also are contingent upon compliance withrequirements 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, and that results in the relocation of the facility's residents who continue to require NF 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 occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another NF.

(c) A facility closure 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, 42 U.S.C. 1396 (April 16, 2015), 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.

(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" and "life care" refer to the living setting 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 or life care community. The individual signs a contract that identifies the continuum of services to be covered by the individual's initial entrance fee and subsequent monthly charges. If a continuing care or life care contract provides for a living arrangement 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 or life 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 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 under the conditions in rule 5160:1-3-05.1 of the Administrative Code.

(3) "Failure to pay" means that an individual 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. An individual shall be considered to have failed to have the individual's care paid for when the individual has 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, the director of ODM upheld the denial.

(4) "Medicaid eligible" means an individual has been determined eligible by the CDJFS under Chapter 5160:1-3 of the Administrative Code and has been issued an effective date of health care coverage for the time period in question.

(5) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates a NF.

(6) "Voluntary withdrawal" means that the operator of a NF, in compliance with section

1919(c)(2)(F) of the Social Security Act, voluntarily elects to withdraw from participation in the medicaid program but chooses to continue providing services of the type provided by NFs.

(B) A provider of a NF shall:

(1) Execute the provider agreement in the format provided by ODM.

(2) Apply for and maintain a valid license to operate if required by law.

(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 in rule 5160-3-20 of the Administrative Code.

(5) Open all records relating to the costs of its services for inspection and audit by ODM and otherwise comply with rule 5160-3-20 of the Administrative Code.

(6) Supply to ODM such information as the department requires concerning NF services to individuals who are medicaid eligible or who have applied to be medicaid recipients.

(7) Unless the conditions described in paragraph (H) of this rule are applicable, retain as a resident any individual who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in a NF who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility are considered residents in the NF during any absence for which bed-hold days are reimbursed in accordance with rule 5160-3-16.4 of the Administrative Code.

(8) Unless the conditions described in paragraph (H) of this rule are applicable, admit as a resident 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 unless at least twenty-five per cent of the NF's medicaid certified beds are occupied by medicaid recipients at the time the individual would otherwise be admitted, in accordance with section 5165.08 of the Revised Code.

(a) In order to comply with these provisions, the NF admission policy shall be designed to admit

individuals sequentially based on the following:

(i) The requested admission date.

(ii) The date and time of receipt of the request.

(iii) The availability of the level of care or range of services necessary to meet the needs of the applicants.

(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 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 ODM, the CDJFS, and 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 5160-3-16.4 of the Administrative Code must be readmitted to the first available semi-private bed in accordance with the provisions of rule 5160-3-16.4 of the Administrative Code.

(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.

(iii) Facility has a religious sponsor.

Any religious or denominational NF that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination.

(iv) NF has continuing care or life care contracts.

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

(v) Prolonged "medicaid pending" application status.

A NF 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 shall submit the necessary documentation in a timely manner as required in rules 5160-3-15.1 and 5160-3-15.2 of the Administrative Code.

(9) Provide the following necessary information to ODM and the CDJFS to process records for payment and adjustment:

(a) Submit the ODM 09401 "Facility/CDJFS Transmittal" (7/2014) to the CDJFS to inform the CDJFS of any information regarding a specific resident for maintenance of current and accurate records at the CDJFS and the facility.

(b) Submit claims to ODM as required in rule 5160-3-39.1 of the Administrative Code.

(10) Permit access to the facility and the facility's records for inspection by ODM, ODH, the 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 operator as defined in section 5165.01 of the Revised Code, follow the procedures in paragraphs (B)(11)(a) to (B)(11)(d) of this rule.

(a) The exiting operator or owner and entering operator must provide a written notice to ODM, as provided in section 5165.51 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 NF, 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 5165.42 of the Revised Code.

(b) The entering operator must submit documentation of any transaction (e.g., sales agreement, contract, or lease) as requested by ODM to determine whether a change of operator has occurred as specified in section 5165.51 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 ODM rules, the provisions of the assigned provider agreement, and any existing CMS 2567 "Statement of Deficiencies and Plan of Correction" (rev. 2/1999) 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 ODH. There may be gaps in medicaid coverage at the facility.

(12) Ensure the security of all personal funds of residents in accordance with rule 5160-3-16.5 of the Administrative Code.

(13) Comply with Title VI and Title VII of the Civil Rights Act of 1964, 42 U.S.C. 1971 (July 27, 2006) and the Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq (March 15, 2011), and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.

(14) Provide notice to ODM within thirty days of any bankruptcy or receivership pertaining to the provider. Notice shall be mailed to: "Office of Legal Services, Ohio Department of Medicaid, P.O. Box 182709, Columbus, Ohio 43218" and to: "Office of the Attorney General, 30 East Broad Street, 14th Floor, Columbus, Ohio 43215".

(15) 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.

(16) Comply with the requirements in rule 5160-3-04.1 of the Administrative Code to repay ODM the federal share of payments under the circumstances required by sections 5165.71 and 5165.85 of the Revised Code.

(17) During a closure or voluntary withdrawal from the medicaid program, provide ODM, the resident or guardian, and the residents' sponsors a written notice 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 section 5165.42 of the Revised Code.

(18) 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 ODM within fourteen days after the last medicaid funded resident has been relocated.

(C) A provider of a NF 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 regardless of payment source. This provision does not prohibit a third party from voluntarily making payment on behalf of an individual.

(D) ODM shall:

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

(2) In the case of a change of operator, issue an assigned provider agreement to the entering operator contingent upon the entering operator's compliance with paragraph (B)(11)(c) of this rule.

(3) Provide access on the ODM website to a listing of the rules ODM has filed for adoption, admendment, or rescission under section 119.03 or 111.15 of the Revised Code.

(4) Make payments in accordance with Chapter 5165. of the Revised Code and Chapter 5160-3 of the Administrative Code to the NF for services to individuals eligible and approved for payment under the medicaid program.

(E) ODM may terminate, suspend, not enter into, or not revalidate, the provider agreement upon thirty days written notice to the provider for violations of Chapters 5164. and 5165. of the Revised Code; Chapters 5160-1 and 5160-3 of the Administrative Code; and if applicable, subject to Chapter 119. of the Revised Code.

(F) Any NF 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 5165.99 of the Revised Code.

(G) The CDJFS shall use the ODM 09401 to communicate with NFs regarding the assessment of payment for specific individuals.

(H) 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 if the individual meets one of the following conditions:

(1) The individual requires a level of care or range of services that the NF is not certified or otherwise qualified to provide.

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