
DEPARTMENT OF HEALTH

General and city health districts

- Authorizes the Ohio Department of Health (ODH) to require general or city health districts to enter into shared services agreements, and authorizes ODH to offer financial and technical assistance to boards of health to encourage the sharing of services.
- Authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district under certain circumstances.
- Authorizes the ODH Director to require general or city health districts to apply for accreditation by July 1, 2018, and to be accredited by July 1, 2020, as a condition precedent to receiving funding from the ODH.
- Requires the ODH Director, by July 1, 2016 to conduct an evaluation of health districts' preparation for accreditation.
- Eliminates a requirement that two or more city health districts be contiguous to form a single city health district.
- Eliminates the requirements (1) that two or more general health districts be contiguous to form a combined general health district and (2) that not more than five contiguous general health districts may combine to form a general health district.
- Requires the ODH Director to adopt rules to assure annual completion of two hours of continuing education by each member of a board of health and specifies the topics of education.
- Eliminates the Public Health Standards Task Force that assists and advises the ODH Director in the adoption of standards for boards of health.
- Requires the ODH Director, not later than July 1, 2014, to establish by rule a standardized process by which all general and city health districts must collect and report to the Director information about public health quality indicators, and a policy and procedures for sharing the reported health data with other specified persons.

Patient Centered Medical Home Program

- Establishes in ODH the Patient Centered Medical Home Program (which is separate from the existing Patient Centered Medical Home Education Program).
- Requires ODH to establish a patient centered medical home certificate and specifies the requirements and goals to be achieved through voluntary certification.
- Permits ODH to establish an application and annual renewal fee for certification.
- Requires each certified patient centered medical home to report health care quality and performance information to the ODH.
- Requires ODH to submit a report to the Governor and General Assembly three and five years after ODH adopts rules to certify patient centered medical homes.

Regulation of ambulatory surgical facilities

- Specifies in statute provisions similar to existing administrative rules requiring each ambulatory surgical facility (ASF) to maintain an infection control program and generally have a written transfer agreement with a local hospital.
- Prohibits an ASF in which abortions are performed or induced from having a written transfer agreement with a public hospital or entering into a contract or similar agreement with a physician who has staff membership or professional privileges at a public hospital.
- Requires the ODH Director to specify ASF inspection forms in rules, conduct inspections of ASFs that are not certified by the federal Centers for Medicare and Medicaid Services, and deny license renewals unless certain conditions are met.
- Requires an ASF to notify the ODH Director within certain time frames when it modifies its most recent written transfer agreement or operating procedures or protocols, or becomes aware of an event that adversely affects a consulting physician's ability to practice or admit patients to a local hospital.

Prioritized distribution of funds for family planning

- Establishes levels of priority regarding the distribution of public funds used for family planning services, including funds received from the federal government.

Management of resident's financial affairs

- Increases the maximum amount that a home that manages a resident's financial affairs may keep in a noninterest bearing account.



Nursing facilities' plans of correction

- Requires a nursing facility's plan of correction regarding certain findings to include an explanation of how actions taken to correct the finding are part of the nursing facility's actions to meet the standards and implement best practices established under the Quality Assurance and Performance Improvement program.

Nursing facility technical assistance

- Eliminates a requirement that ODH provide advice and technical assistance and conduct on-site visits to nursing facilities for the purpose of improving resident outcomes.
- Eliminates a requirement that ODH annually report those activities and their effectiveness to the Governor and General Assembly.

Board of Executives of Long-Term Services and Supports

- Renames the Board of Examiners of Nursing Home Administrators to the Board of Executives of Long-Term Services and Supports.
- Increases, from 9 to 11, the number of Board members and modifies the eligibility requirements for Board members.
- Requires the Board to enter into a written agreement with ODH for ODH to serve as the Board's fiscal agent.
- Requires the Board to create opportunities for education, training, and credentialing of nursing home administrators and others in leadership positions in long-term services and supports settings.
- Provides guidelines for the Board's agency transition, membership changes, and name change, including provisions governing the transfer of duties and obligations.

Distribution of state household sewage treatment system permit fees

- Reallocates the distribution of money collected from state household sewage treatment system permit fees by:
 - Decreasing the percentage of money allocated to fund installation and evaluation of sewage treatment system new technology pilot projects; and
 - Increasing the percentage of money allocated for use by the ODH Director to administer and enforce the Household and Small Flow On-Site Sewage Treatment Systems Law and rules adopted under it.



Water systems

- Exempts a water system that does not provide water for human consumption from obtaining a permit or license, paying fees, or complying with any rule adopted under the existing statutes governing private water systems, which are systems that provide water for human consumption.

Ohio Cancer Incidence Surveillance System

- Authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System.
- Repeals provisions expressly governing the confidentiality of cancer information provided to or acquired by an Ohio cancer registry or ODH, but continues general provisions governing the confidentiality of protected health information.

Zoonotic disease program

- Authorizes the ODH Director, if a zoonotic disease program is administered by ODH, to charge a local board of health a fee for each service the program provides to the board.

Other provisions

- Requires the ODH Director to adopt rules governing the distribution of funds in fiscal years 2014 and 2015 to assist families in purchasing hearing aids for children.
- Eliminates the January 1 deadline for the ODH Director to determine the changes in charges that may be imposed for copies of medical records.
- Eliminates a requirement that trauma centers report to the ODH Director information on preparedness and capacity to respond to disasters, mass casualties, and bioterrorism.
- Abolishes the Council on Stroke Prevention and Education.
- Specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.
- Requires ODH to process an application for a Women, Infants, and Children (WIC) vendor contract within 45 days if the applicant already has a WIC vendor contract.

General and city health districts

Expansion of ODH's authority over health districts

(R.C. 3701.13)

The bill authorizes the Department of Health (ODH) to require general or city health districts to enter into shared services agreements under existing law¹¹⁸ that permits a political subdivision to enter into an agreement with another political subdivision whereby a contracting political subdivision agrees to exercise any power, perform any function, or render any service for another recipient political subdivision that the recipient political subdivision is otherwise legally authorized to exercise, perform, or render. ODH must prepare and offer to boards of health a model contract and memorandum of understanding that are easily adaptable for use by the boards when entering into shared services agreements. ODH also may offer financial and other technical assistance to boards of health to encourage the sharing of services.

The bill authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district when an emergency exists, or when the board of health of the general or city health district has neglected or refused to act with sufficient promptness or efficiency or has not been lawfully established.

Accreditation of general and city health districts

(R.C. 3701.13)

As a condition precedent to receiving funding from ODH, the bill authorizes the ODH Director to require general or city health districts to apply for accreditation by July 1, 2018, and to be accredited by July 1, 2020, by an accreditation body approved by the ODH Director. By July 1, 2016, the ODH Director must conduct an evaluation of general and city health district preparation for accreditation, including an evaluation of each district's reported public health quality indicators.

Formation of combined general or city health districts

(R.C. 3709.01, 3709.051, and 3709.10)

The bill eliminates the requirement that city health districts be contiguous to form a single city health district. Under existing law, two or more contiguous city health districts may be united to form a single city health district by a majority affirmative vote

¹¹⁸ R.C. 9.482, not in the bill.



of the legislative authority of each city affected by the union, or by petition of at least 3% of the qualified electors residing within each of the two or more contiguous city health districts.

The bill also eliminates the requirement that general health districts be contiguous to form a single general health district, and eliminates the limitation that not more than five general health districts may combine to form a single general health district. Existing law authorizes two or more contiguous general health districts, not to exceed five, to unite in the formation of a single general health district if approved by an affirmative majority vote of the district advisory councils. The bill's revisions result in authorization for an unlimited number of noncontiguous general health districts to form a single general health district.

Continuing education for board of health members

(R.C. 3701.342)

The bill adds to the minimum standards for boards of health that the ODH Director is required to adopt, rules that assure annual completion of two hours of continuing education by each member of a board of health. The standards must provide that continuing education credits earned for license renewal or certification by licensed health professionals serving on boards of health may be counted to fulfill the two-hour continuing education requirement. The minimum standards must provide that the continuing education credits shall pertain to ethics, public health principles, and a member's responsibilities. Credits may be earned in these topics at pertinent presentations that may occur during regularly scheduled board meetings throughout the calendar year or at other programs available for continuing education credit. The ODH Director may assist local boards of health of general and city health districts in coordinating approved continuing education programs sponsored by health care licensing boards, commissions, or associations.

The minimum standards also shall provide that continuing education credits earned for the purpose of license renewal or certification by licensed health professionals serving on boards of health may be counted to fulfill the two-hour education requirement.

Elimination of Public Health Standards Task Force

(R.C. 3701.342; R.C. 3701.343 (repealed))

The bill eliminates the nine-member Public Health Standards Task Force that assists and advises the ODH Director in formulating and evaluating public health



services standards for boards of health. Currently, the ODH Director adopts the standards by rule, after consulting with the Task Force.

Standardized reporting of public health data

(R.C. 3701.98)

The bill requires the ODH Director, not later than July 1, 2014, to establish both of the following by rule adopted under the Administrative Procedure Act:¹¹⁹

(1) A standardized process by which all general and city health districts must collect and report to the Director information regarding public health quality indicators.

(2) A policy and procedures for the sharing of health data reported under (1), above, with payers, providers, general and city health districts, and public health professionals.

The rules must identify the public health quality indicators that are to be a priority for general and city health districts, and the information to be collected and reported regarding those indicators. The Director must work with the Association of County Health Commissioners in identifying the indicators.

Patient Centered Medical Home Program

(R.C. 3701.921, 3701.922, 3701.94, 3701.941, 3701.942, 3701.943, and 3701.944)

The bill establishes the Patient Centered Medical Home (PCMH) Program in ODH. The PCMH Program is established separately from the existing PCMH Education Program, and the ODH Director's authority to establish pilot projects that evaluate and implement the PCMH model of care under that program is eliminated. A PCMH model of care is an advanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive coordinated patient centered care.

Voluntary PCMH certification program

As part of the PCMH Program, ODH is required to establish a voluntary PCMH certification program.

¹¹⁹ Rulemaking under the Administrative Procedure Act, R.C. Chapter 119., requires notice and a public hearing.



Goals of PCMH Program

Through certification of PCMHs, ODH is to seek to do all of the following:

- (1) Expand, enhance, and encourage the use of primary care providers, including primary care physicians, advanced practice registered nurses, and physician assistants, as personal clinicians;
- (2) Develop a focus on delivering high-quality, efficient, and effective health care services;
- (3) Encourage patient centered care and the provision of care that is appropriate for a patient's race, ethnicity, and language;
- (4) Encourage the education and active participation of patients and patients' families or legal guardians, as appropriate, in decision making and care plan development;
- (5) Provide patients with consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care;
- (6) Ensure that PCMHs develop and maintain appropriate comprehensive care plans for patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;
- (7) Ensure that PCMHs plan for transition of care from youth to adult to senior; and
- (8) Enable and encourage use of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables those professionals to practice to the fullest extent of their professional licenses.

Certification requirements

A primary care practice that seeks PCMH certification must submit an application and pay any application fee ODH establishes. ODH may also require an annual renewal fee. If ODH establishes a fee, the fee must be in an amount sufficient to cover the cost of any on-site evaluations.

Each primary care practice with PCMH certification must do all of the following:

- (1) Meet any standards developed by national independent accrediting and medical home organizations, as determined by ODH;



(2) Develop a systematic follow-up procedure for patients, including the use of health information technology and patient registries;¹²⁰

(3) Implement and maintain health information technology that meets the requirements of federal law;¹²¹

(4) Report to ODH health care quality and performance information, including any data necessary for monitoring compliance with certification standards and for evaluating the impact of PCMHs on health care quality, cost, and outcomes;

(5) Meet any process, outcome, and quality standards ODH specifies; and

(6) Meet any other requirements ODH establishes.

Data collection

ODH is authorized to contract with a private entity to evaluate the effectiveness of certified PCMHs. ODH may provide to the entity any health care quality and performance information data that ODH has. ODH may also contract with national independent accrediting and medical home organizations to provide on-site evaluation of primary care practices and verification of data collected by ODH.

Report

The bill requires ODH to submit a report to the Governor and General Assembly evaluating the PCMH Program no later than three and five years after first establishing the standards and procedures for certifying a primary care practice as a PCMH, the types of medical practices that constitute primary care practices eligible for certification, and the health care quality and performance information that a certified PCMH must report to ODH.

Each of the reports must include all of the following:

(1) The number of patients receiving primary care services from certified PCMHs and the number and characteristics of those patients with complex or chronic conditions. To the extent available, information regarding the income, race, ethnicity, and language of the patients is to be included in the report;

¹²⁰ According to the National Center for Biotechnology Information, U.S. National Library of Medicine, "patient registry" refers to an organized system that uses observational study methods to collect uniform data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes (www.ncbi.nlm.nih.gov/books/NBK49448/).

¹²¹ 42 U.S.C. 300jj.

- (2) The number and geographic distribution of certified PCMHs;
- (3) Performance of and quality of care measures implemented by certified PCMHs;
- (4) Preventative care measures implemented by certified PCMHs;
- (5) Payment arrangements of certified PCMHs;
- (6) Costs related to implementation of the PCMH Program and payment of care coordination fees;
- (7) The estimated effect of certified PCMHs on health disparities; and
- (8) The estimated savings from establishing the PCMH Program, as those savings apply to the fee for service, managed care, and state-based purchasing sectors.

Regulation of ambulatory surgical facilities

(R.C. 3702.30 and 3702.302 to 3702.308)

Overview

The bill requires each ambulatory surgical facility (ASF) to (1) maintain an infection control program and (2) in general, have a written transfer agreement with a local hospital that specifies an effective procedure for the transfer of patients from the facility to the hospital when medical care beyond the care that can be provided at the ASF is necessary. These requirements are similar to those in current rules the ODH Director has adopted establishing quality standards for specified types of health care facilities subject to ODH licensure.¹²² In addition, the bill requires that an ASF notify the Director when certain events occur and specifies certain requirements related to ASF inspections.

Infection control programs

Relative to infection control programs, the bill specifies that each program's purposes are to minimize infections and communicable diseases and facilitate a functional and sanitary environment consistent with standards of professional practice. To achieve these purposes, the bill requires ASF staff managing a program to create and administer a plan designed to prevent, identify, and manage infections and communicable diseases; ensure that the program is directed by a qualified professional

¹²² Ohio Administrative Code (O.A.C.) 3701-83-09(D) and 3701-83-19(E). An ASF is one of six types of health care facilities subject to these quality standards and licensing provisions (R.C. 3702.30(A)(4)).

trained in infection control; ensure that the program is an integral part of the ASF's quality assessment and performance improvement program; and implement in an expeditious manner corrective and preventive measures that result in improvement.

Under current rules, an ASF must establish and follow written infection control policies and procedures for the surveillance, control and prevention, and reporting of communicable disease organisms by both contact and airborne routes. These must be consistent with current infection control guidelines issued by the U.S. Centers for Disease Control and Prevention. The policies and procedures must address use of protective clothing and equipment; storage, maintenance, and distribution of sterile supplies and equipment; disposal of biological waste (including blood, body tissue, and fluid) in accordance with Ohio law; standard precautions or body substance isolation (or the equivalent); and tuberculosis and other airborne diseases.¹²³

Written transfer agreements

Requirement

The bill generally requires each ASF to have a written transfer agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the ASF to the hospital when medical care beyond the care that can be provided at the ASF is necessary. This includes situations when emergencies occur or medical complications arise. A copy of the agreement must be filed with the ODH Director and an ASF must update an agreement every two years and file the updated agreement with the Director.

The bill specifies that an ASF is not required to have a written transfer agreement if either of the following is the case:

(1) The ASF is a provider-based entity of a hospital and the ASF's policies and procedures to address such situations are approved by the governing body of the facility's parent hospital and implemented. Under federal law, a "provider-based entity" is a provider of health care services or a rural health clinic that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider and that is under the ownership and administrative and financial control of the main provider. (A provider-based entity comprises both the specific physical facility that serves as the site of services of a type

¹²³ O.A.C. 3701-83-09(D).

for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility.)¹²⁴

(2) The ODH Director has granted the ASF a variance pursuant to the procedure specified in the bill.

The bill's requirement is similar to the written transfer agreement requirement in current rule. The rule requires an ASF to have a written transfer agreement with a hospital for the transfer of patients in the event of "medical complications, emergency situations, and for other needs as they arise." It specifies that a formal agreement is not required, however, in those instances where the ASF is a provider-based entity of a hospital and the ASF policies and procedures to accommodate medical complications, emergency situations, and for other needs as they arise are in place and approved by the governing body of the parent hospital.¹²⁵

Public hospital exclusion regarding abortion

The bill prohibits an ASF in which abortions are performed or induced from having a written transfer agreement with a public hospital or entering into a contract or similar agreement with a physician who has been granted staff membership or professional privileges by the governing body of a public hospital. The bill defines "public hospital" as a hospital registered with ODH that is owned, leased, or controlled by the state or any agency, institution, instrumentality, or political subdivision of the state. A public hospital includes any state university, state medical college, health district, joint hospital, or public hospital agency.

Variations

Application. The bill authorizes the ODH Director to grant a variance from the written transfer agreement requirement if the ASF submits to the Director a complete variance application prescribed by the Director and the Director determines (after reviewing the application) that the ASF is capable of achieving the purpose of the written transfer agreement in the absence of one. The bill specifies that the Director's determination is final.

A variance application is complete if it contains or includes as attachments all of the following:

¹²⁴ 42 C.F.R. 413.65(a)(2).

¹²⁵ O.A.C. 3701-83-19(E).



--A statement explaining why application of the requirement would cause the ASF undue hardship and why the variance will not jeopardize the health and safety of any patient;

--A letter, contract, or memorandum of understanding signed by the ASF and one or more consulting physicians who have admitting privileges at a minimum of one local hospital, memorializing the physician or physicians' agreement to provide back-up coverage when medical care beyond the level the ASF can provide is necessary;

--For each consulting physician described above, all of the following:

- A signed statement in which the physician attests that the physician is familiar with the ASF and its operations and agrees to provide notice to the ASF of any changes in the physician's ability to provide back-up coverage;
- The estimated travel time from the physician's main residence or office to each local hospital where the physician has admitting privileges;
- Written verification that the ASF has record of the name, telephone numbers, and practice specialties of the physician;
- Written verification from the State Medical Board that the physician possesses a valid certificate to practice medicine and surgery or osteopathic medicine and surgery;
- Documented verification that each hospital at which the physician has admitting privileges has been informed in writing by the physician that the physician is a consulting physician for the ASF and has agreed to provide back-up coverage for the ASF when medical care beyond the care the ASF can provide is necessary;
- A copy of the ASF's operating procedures or protocols that, at a minimum, do all of the following: (1) address how back-up coverage by consulting physicians is to occur, including how back-up coverage is to occur when consulting physicians are temporarily unavailable, (2) specify that each consulting physician is required to notify the ASF, without delay, when the physician is unable to expeditiously admit patients to a local hospital and provide for continuity of care, and (3) specify that a patient's medical record maintained by the ASF must be transferred contemporaneously with the patient when the patient is transferred from the ASF to a hospital;
- Any other information the Director considers necessary.

Under current rule, an ASF must submit an application for a variance containing the specific nature of the request and the rationale for the request; the specific building or safety requirement in question, with a reference to the relevant rule; the time period for which the variance is requested; and a statement of how the ASF will meet the intent of the requirement in an alternative manner.¹²⁶

Decision. The bill specifies that the ODH Director's decision to grant, refuse, or rescind a variance is final. The Director must consider each application for a variance independently without regard to any decision the Director may have made on a prior occasion to grant or deny a variance to that ASF or another ASF.

The bill's requirement is similar to one in current rule. The rule:¹²⁷

--Authorizes the Director to grant a variance if the Director determines that the requirement has been met in an alternative manner;

--Specifies that the Director's refusal to grant a variance is final and does not create any rights to an administrative hearing;

--Prohibits the Director's granting of a variance to be construed as constituting precedence for the granting of any other variance; and

--Specifies that variance requests must be considered on a case-by-case basis.

Conditions; revocation. The bill also authorizes the ODH Director to impose conditions on any variance the Director has granted. The Director may at any time rescind the variance for any reason, including a determination by the Director that the ASF is failing to meet one or more of the conditions or no longer adequately protects public health and safety. The bill specifies that the Director's decision to rescind a variance is final.

Similar authorizations are incorporated in current rule.¹²⁸

Duration. The bill specifies that a variance is effective for the period of time specified by the ODH Director, except that it cannot be effective beyond the date the ASF's license expires. If a variance is to expire on the date the ASF's license expires, the ASF may submit to the Director an application for a new variance with its next license renewal application.

¹²⁶ O.A.C. 3701-83-14(B).

¹²⁷ O.A.C. 3701-83-14(C), (F), and (G).

¹²⁸ O.A.C. 3701-83-14(E).

Current rule specifies that the Director may stipulate a time period for which a variance is to be effective. The time period may be different than the time period sought by the ASF in the written variance request.¹²⁹

Inspections

The bill requires that rules the ODH Director must adopt under current law establishing quality standards for health care facilities include provisions specifying the inspection form that must be used during ASF inspections. The bill also requires the Director to conduct an inspection of any ASF that is not certified by the federal Centers for Medicare and Medicaid as an ambulatory surgical center each time the ASF submits a license renewal application. Under current rules, the Director is not required to make any inspections, but is permitted to make them at any time as the Director considers necessary or for the purpose of investigating alleged violations of law governing health care facilities.¹³⁰

The bill prohibits the Director from renewing an ASF license unless all of the following conditions are met:

(1) The inspector completes each item on the inspection form that must be used during ASF inspections (the form approved by the Director on the bill's effective date is to be used until rules are adopted under the bill specifying the form to be used);

(2) The inspection demonstrates that the ASF complies with all quality standards established by the Director in rules;

(3) The Director determines that the most recent version of the updated written transfer agreement that the ASF files with the Director is satisfactory, unless the Director has granted a variance from the written transfer agreement requirement.

Notifications

The bill requires an ASF to notify the ODH Director under all of the following circumstances:

¹²⁹ O.A.C. 3701-83-14(D).

¹³⁰ O.A.C. 3701-83-06(A) and (E).



(1) When the ASF modifies any provision of the most recent written transfer agreement it has filed with the Director. Notification under these circumstances must occur not later than the business day after the modification is finalized.¹³¹

(2) When the ASF modifies its operating procedures or protocols that address back-up coverage for consulting physicians and medical record maintenance and transfers. Notification under these circumstances must occur not later than 48 hours after the modification is made.

(3) When the ASF becomes aware of an event, including disciplinary action by the State Medical Board, that may affect a consulting physician's certificate to practice or the physician's ability to admit patients to a hospital identified in a variance application. Notification under these circumstances must occur not later than one week after the ASF becomes aware of the event's occurrence.

Current rules do not contain similar requirements.

Severability clause

If any provision of the new sections of law the bill enacts regarding ASFs (R.C. 3702.302 to 3702.307) are enjoined, the bill specifies that the injunction does not affect any remaining provision of those sections, any provision of the current law section governing ASFs (R.C. 3702.30), or any provision of the rules adopted under that section.

Prioritized distribution of funds for family planning

(R.C. 3701.027, 3701.033, 5101.101, 5101.46, and 5101.461)

The bill requires that ODH and the Ohio Department of Job and Family Services (ODJFS), when distributing funds for family planning services, award them first to public entities that (1) have applied for funding, (2) are operated by state or local government entities, and (3) provide or are able to provide family planning services. If any funds remain after distributing funds to those public entities, the bill permits ODH and ODJFS to distribute funds to nonpublic entities in the following order of descending priority:

(1) Nonpublic entities that are federally qualified health centers (FQHCs), FQHC look-alikes, or community action agencies;

¹³¹ The bill defines "business day" as a day of the week excluding Saturday, Sunday, and a legal holiday (see R.C. 1.14).



(2) Nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services;

(3) Nonpublic entities that provide family planning services, but do *not* provide comprehensive primary and preventive care services.

Federal funds

The funds subject to the priority levels described above include federal funds received under (1) the Maternal and Child Health Block Grant (Title V of the Social Security Act), (2) the Family Planning Program (Title X of the Public Health Service Act), (3) the Social Services Block Grant (Title XX of the Social Security Act), and (4) the Temporary Assistance for Needy Families Block Grant (TANF, Title IV-A of the Social Security Act), to the extent that TANF funds are being used by Ohio to provide Title XX social services.

Exemptions

The bill exempts from the prioritized distribution both of the following: (1) the Medicaid program and (2) funds awarded by ODH as women's health services grants.

Management of resident's financial affairs

(R.C. 3721.15)

Under current law, a home (including a nursing home, assisted living facility, and veterans' home) that manages a resident's financial affairs must deposit any amount in excess of \$100 in an interest-bearing account, separate from any of the home's operating accounts. Under the bill, a home is not required to place a resident's funds in an interest-bearing account unless the funds exceed \$1,000.

Nursing facilities' plans of correction

(R.C. 5165.69)

Nursing facilities are required to undergo surveys to determine whether they continue to meet the requirements for certification to participate in the Medicaid program. Continuing law requires a nursing facility that receives a statement of deficiencies following a survey to submit to ODH a plan of correction for each finding cited in the statement. The bill requires a nursing facility's plan of correction to include additional information.

Under continuing law, a plan of correction must describe the actions the nursing facility will take to correct each finding and specify the date by which each finding will



be corrected. In the case of a finding that existed during the period between two surveys and that the nursing facility substantially corrected before the second survey, a plan of correction must describe the actions that the facility took to correct the finding and the date on which it was corrected.

Under the bill, the part of a plan of correction that describes the actions the nursing facility will take to correct each finding must be detailed. Beginning one year after the effective date of the first federal regulation promulgated under a provision of the Patient Protection and Affordable Care Act regarding a quality assurance and performance improvement (QAPI) program, a plan of correction for a finding assigned a severity level indicating that a resident was harmed or immediate jeopardy exists is required to include an explanation of how actions to correct the finding are part of the nursing facility's actions to meet the standards and implement the best practices established under the QAPI program.

Current law requires ODH to approve a nursing facility's plan of correction, and any modification of an existing plan, that conforms to the requirements for approval established in federal regulations, guidelines, and procedures issued by the U.S. Secretary of Health and Human Services under federal Medicare and Medicaid Law. The bill adds an extra condition for ODH approval: a plan of correction must include all the information that continuing law and the bill require.

Nursing facility technical assistance

(R.C. 3721.027; R.C. 3721.026 (repealed))

The bill repeals a requirement that the ODH Director establish a unit within ODH to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes. With the repeal, the Director is no longer required to submit an annual report to the Governor and General Assembly describing the unit's activities for the year and its effectiveness in improving resident outcomes.

Board of Executives of Long-Term Services and Supports

(R.C. 4751.01 to 4751.08 and 4751.10 to 4751.13; conforming changes in R.C. 149.43 and 1347.08)

The bill renames the Board of Examiners of Nursing Home Administrators to the Board of Executives of Long-Term Services and Supports. The bill defines "long-term services and supports settings" as any institutional or community-based setting in which medical, health, psycho-social, habilitative, rehabilitative, or personal care services are provided to individuals on a post-acute care basis.



The bill makes further changes to the Board's membership and duties, explained in more detail below.

Board membership changes

(R.C. 4751.03)

The bill modifies the number and qualifications of Board members. Under the bill, the Board is to consist of the following 11 members, all appointed by the Governor:

- Four members who are nursing administrators, owners of nursing homes, or officers of corporations owning nursing homes, and who have an understanding of person-centered care and experience with a range of long-term services and supports settings;
- Three members (1) who work in long-term services and supports settings that are not nursing homes, and who have an understanding of person-centered care and experience with a range of long-term services and supports settings, and (2) at least one of whom also must be a home health administrator, an owner of a home health agency, or an officer of a home health agency;
- One member who is a member of the academic community;
- One member who is a consumer of services offered in a long-term services and supports setting;
- One member who is a representative of ODH, designated by the ODH Director, who is involved in the nursing home survey and certification process;
- One member who is a representative of the Office of the State Long-Term Care Ombudsman, designated by the State Long-Term Care Ombudsman.

The bill prohibits the following Board members from having or acquiring any direct financial interest in a nursing home or long-term services and supports settings: the member representing the academic community, the consumer member, and the members representing ODH and the Ombudsman.

The bill retains current law provisions governing the Board's administration, including quorum requirements, election of a chairperson and vice-chairperson, removal of members by the Governor, and meeting requirements. Additionally, the bill preserves the current law provision that Board members are to serve three-year terms, and that no member is permitted to serve more than two consecutive full terms. The bill



also retains a requirement of current law that all Board members must be U.S. citizens and residents of Ohio.

Under current law, the Board consists of nine members, all appointed by the Governor. Eight members of the Board are representative of the professionals and institutions concerned with care and treatment of chronically ill or infirm aged patients and one member is a public member, at least 60 years of age. Further, current law requires that four members of the Board must be nursing home administrators, owners of nursing homes, or an officer of a corporation owning a nursing home. Current law also requires that less than a majority of the Board members may represent a single profession or institutional category. Under current law, a person appointed as a noninstitutional member is prohibited from having or acquiring any direct financial interest in a nursing home.

Board member transition

(Section 515.40)

The bill requires that, notwithstanding the provision describing the Board's membership above, the individuals serving as members of the Board of Examiners of Nursing Home Administrators (current Board) on the bill's effective date are to continue to serve as members of the Board of Executives of Long-Term Services and Supports (new Board). The expiration date of these members' terms is to be the date on which their terms as members of the current Board are set to expire. At the time such members' terms expire, members are to be appointed to the new Board in accordance with the requirements outlined above.

Within 90 days after the bill's effective date, the Governor is required to appoint to the new Board the member representing the academic community, the consumer member, and the members representing ODH and the Ombudsman. The initial terms for these members will end on May 27, 2014. After this initial term, the terms are to be for the duration provided above.

Board member compensation

(R.C. 4751.03(E))

The bill updates a provision of current law by stating that each Board member must be reimbursed for actual and necessary expenses incurred in the discharge of Board duties. Further, all Board members, except for the member designated by the ODH Director and the member designated by the Ombudsman, are to be paid in

accordance with the salaries or wages designated by the Department of Administrative Services.¹³²

Board administration and assistance

(R.C. 4751.03(H))

The bill clarifies that the Board must appoint a secretary with no financial interest in a long-term services and supports setting, instead of a nursing home. Additionally, the bill eliminates the obligation of ODH to provide administrative, technical, or other services to the Board.

Education, training, and credentialing opportunities

(R.C. 4751.04(A)(10))

The bill requires the Board to create opportunities for the education, training, and credentialing of nursing home administrators and others in leadership positions who practice in long-term services and supports settings or who direct the practices of others in those settings. When creating these opportunities, the Board is required to do the following:

- Identify core competencies and areas of knowledge that are appropriate for nursing home administrators and others working within the long-term services and supports settings system, with an emphasis on leadership, person-centered care, principles of management within both the business and regulatory environments, and an understanding of all post-acute settings, including transitions from acute settings and between post-acute settings.
- Assist in the development of a strong, competitive market in Ohio for training, continuing education, and degree programs in long-term services and supports settings administration.

ODH to serve as the Board's fiscal agent

(R.C. 4751.04(A)(9) and 4751.042)

The bill requires the Board to enter into a written agreement with ODH for ODH to serve as the Board's fiscal agent.

¹³² R.C. 124.15(J), not in the bill.



Requirements under the written agreement

Under the bill, ODH is responsible for all the Board's fiscal matters and financial transactions, as specified in the written agreement. The written agreement must specify the fees that the Board is to pay to ODH for services performed under the agreement. The bill provides that such fees must be in proportion to the services performed for the Board by ODH. The bill specifies that ODH, in its role as fiscal agent for the Board, serves as a contractor of the Board, and does not assume responsibility for the debts or fiscal obligations of the Board.

The bill requires ODH to provide the following services under the written agreement:

- Preparation and processing of payroll and other personnel documents that the Board approves;
- Maintenance of ledgers of accounts and reports of account balances, and monitoring of budgets and allotment plans in consultation with the Board;
- Performance of other routine support services, specified in the agreement, that ODH considers appropriate to achieve efficiency.

Permitted terms of the written agreement

Under the bill, the written agreement between the Board and ODH may include provisions for the following:

- Any shared services between the Board and ODH;
- Any other services agreed to by the Board and ODH, including administrative or technical services.

Board responsibilities regarding fiscal and administrative matters

The bill provides that the Board has the sole authority to expend funds from the Board's accounts for programs and any other necessary expenses the Board may incur. Additionally, the bill provides that the Board must inform ODH fully of any financial transactions to ensure compliance with fiscal regulations.

Further, the bill requires the Board to follow all state procurement, fiscal, human resources, information technology, statutory, and administrative rule requirements.

Additional Board transition procedures

(Section 515.40)

The bill sets out terms providing for the transition from the current Board of Examiners of Nursing Home Administrators to the new Board of Executives of Long-Term Services and Supports, including provisions governing the following:

- The transition of assets and liabilities;
- The assumption of obligations and authority by the new Board;
- The effect of the transition on the rights, privileges, and remedies, and duties, liabilities, and obligations accrued by the current Board and their transfer to the new Board;
- The transition of unfinished business that was commenced but not completed by the current Board or the current Board's secretary to the new Board or the new Board's Secretary;
- The continuation of the current Board's rules, orders, and determinations under the new Board;
- Subject to laws governing layoffs of state employees, the transition of employees of the current Board who provide administrative, technical, or other services to the current Board on a full-time, permanent basis to serve under the new Board and provisions requiring that these employees are to retain their positions and benefits, except that those employees in the classified service must be reclassified into the unclassified service and are to serve at the pleasure of the new Board;
- The interpretation of references to the current Board in any statute, contract, or other instrument and deeming the references applicable to the new Board;
- The effect of the transition on pending court or agency actions or procedures and required substitution of the new Board in the old Board's place for such actions or procedures.



Distribution of state household sewage treatment system permit fees

(R.C. 3718.06)

The bill reallocates the distribution of money collected from state household sewage treatment system installation and alteration permit fees as follows:

(1) Decreases the percentage allocated to fund installation and evaluation of sewage treatment new technology pilot projects from not less than 25% as provided in current law to not less than 10%; and

(2) Increases from not more than 75% to not more than 90% the percentage used by the ODH Director to administer and enforce the Household and Small Flow On-site Sewage Treatment Systems Law and rules adopted under it.

Water systems

(R.C. 3701.344)

The bill exempts a water system that does not provide water for human consumption from obtaining a permit or license issued under, paying fees assessed or levied under, or complying with any rule adopted under the existing statutes governing private water systems. A private water system is any water system for the provision of water for human consumption if the system has fewer than 15 service connections and does not regularly serve an average of at least 25 individuals daily at least 60 days out of the year.

Ohio Cancer Incidence Surveillance System

(R.C. 3701.261, 3701.262, 3701.264, and 3701.99; R.C. 3701.263 (repealed))

The bill authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System (OCISS). "State university" means the following: University of Akron, Bowling Green State University, Central State University, University of Cincinnati, Cleveland State University, Kent State University, Miami University, Ohio University, Ohio State University, Shawnee State University, University of Toledo, Wright State University, and Youngstown State University.

The OCISS is a population-based cancer registry established by the ODH Director that collects and analyzes cancer incidence data in Ohio. Each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer must report each case of cancer to ODH. ODH is required to record in the registry all reports of cancer it receives.



In implementing the OCISS, current law requires the ODH Director to:

- Monitor the incidence of various types of malignant diseases in Ohio;
- Make appropriate epidemiologic studies to determine any causal relations of such diseases with occupational, nutritional, environmental, or infectious conditions;
- Alleviate or eliminate any of the conditions listed above;
- Advise, consult, cooperate with, and assist federal, state, and local agencies, universities, private organizations, corporations, and associations; and
- Accept and administer grants from the federal government or other sources.

Confidentiality of cancer reports

Current law includes confidentiality provisions that apply only to information on cancer provided to or obtained by a cancer registry and ODH. It specifies that this information is confidential and is to be used only for statistical, scientific, and medical research for the purpose of reducing the morbidity or mortality of malignant disease. The bill repeals this provision. However, both federal law and Ohio law unchanged by the bill include general provisions governing the confidentiality of protected health information.¹³³

In general, protected health information reported to or obtained by ODH is confidential and cannot be released without the written consent of the individual who is the subject of the information, unless one of the following applies:

(1) The release of the information is necessary to provide treatment to the individual or to ensure the accuracy of the information and the information is released pursuant to a written agreement that requires the recipient of the information to comply with confidentiality requirements.

(2) The information is released pursuant to a search warrant or subpoena issued by or at the request of a grand jury or prosecutor in connection with a criminal investigation or prosecution.

(3) The ODH Director determines the release of the information is necessary to avert or mitigate a clear threat to an individual or to the public health to the extent necessary to control, prevent, or mitigate disease.

¹³³ See the Health Insurance Portability and Accountability Act of 1996, 104 Pub. L. No. 191, 110 Stat. 2021, 42 U.S.C. 1320d *et seq*; 45 C.F.R. 16.304; and R.C. 3701.17, not in the bill.



Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form.

Zoonotic disease program

(R.C. 3701.96)

The bill specifies that if ODH administers a zoonotic disease program, the ODH Director is authorized to charge a local board of health a fee for each service the program provides to the board.¹³⁴ The fee amount must be determined by the Director and be commensurate with ODH's cost to provide the service. The board must pay the fee associated with a service at the time the service is provided.

According to the federal Centers for Disease Control and Prevention (CDC), zoonotic diseases are diseases caused by germs that can be spread between animals and humans. Such germs have been responsible for illnesses and outbreaks, including *Salmonella*, *E. coli* O157:H7, and *Cryptosporidium*. The germs may come from many types of animals, including pets, wild animals, and farm animals.¹³⁵

Financial assistance to purchase hearing aids for children

(Sections 285.10 and 285.20)

The bill requires that the ODH Director adopt rules governing the distribution of the additional \$200,000 it appropriates per fiscal year for fiscal years 2014 and 2015 to assist families in purchasing hearing aids for children under 21 years of age. These must include rules that do both of the following: (1) establish eligibility criteria to include families with incomes at or below 400% of the federal poverty line and (2) develop a sliding scale of disbursements based on family income. The bill authorizes the Director to adopt any other rules necessary to distribute these funds.

¹³⁴ According to an ODH representative, ODH has been administering some form of a zoonotic disease program since 1965. Prior to 2005, the program operated as two separate programs—the Rabies Program and the Vectorborne Disease Program. In 2005, these two programs merged to become the Zoonotic Disease Program. (Electronic correspondence from ODH (May 30, 2013).)

¹³⁵ U.S. Centers for Disease Control and Prevention, *Zoonotic Diseases* (Diseases from Animals) available at www.cdc.gov/zoonotic/gi/.



Charges for copies of medical records

(R.C. 3701.741 and 3701.742)

The bill eliminates a requirement that adjustment to charges that may be imposed for copies of medical records be made not later than January 1 of each year. Current law specifies the amounts that may be charged for medical records, but provides for an annual adjustment based on the Consumer Price Index (CPI). Under the bill, amounts specified in statute plus any previous adjustments must be increased or decreased by the average percentage of increase or decrease in the CPI for the immediately preceding calendar year over the calendar year immediately preceding that year.

The bill eliminates a requirement that the ODH Director provide a list of the adjusted amounts on request but maintains a requirement that the list be available on ODH's Internet site.

Trauma center preparedness report

(R.C. 149.43; R.C. 3701.072 (repealed))

Under current law, the ODH Director must adopt rules requiring a trauma center to report to the ODH Director information on the center's preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. The ODH Director is required to review the information and, after the review, may evaluate the center's preparedness and capacity. The bill eliminates the requirement that the ODH Director adopt those rules and the accompanying authority to evaluate the center's preparedness and capacity.

Council on Stroke Prevention and Education

(R.C. 3701.90, 3701.901, 3701.902, 3701.903, 3701.904, 3701.905, 3701.906, and 3701.907 (repealed))

The bill abolishes the Council on Stroke Prevention and Education, a council that was established within ODH in 2001 to do the following:

- Develop and implement a comprehensive statewide public education program on stroke prevention, targeted to high-risk populations and to geographic areas where there is a high incidence of stroke;
- Develop or compile for primary care physicians recommendations that address risk factors for stroke, appropriate screening for risk factors, early signs of stroke, and treatment strategies;



- Develop or compile for physicians and emergency health care providers recommendations on the initial treatment of stroke;
- Develop or compile for physicians and other health care providers recommendations on the long-term treatment of stroke;
- Develop or compile for physicians, long-term care providers, and rehabilitation providers recommendations on rehabilitation of stroke patients; and
- Take other actions consistent with the purpose of the council.

The Council was required to meet at least once annually, at the call of the chair, to review and make amendments as necessary to the recommendations developed or compiled by the Council.

System for Award Management web site

(R.C. 3701.881)

Continuing law requires an individual to undergo a database review as part of a criminal records check if the individual is under final consideration for employment with (or is referred by an employment service to) a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an individual. The ODH Director is permitted to adopt rules also requiring individuals already employed by (or referred to) home health agencies in such positions to undergo the database reviews. A home health agency is a person or government entity (other than a nursing home, residential care facility, hospice care program, or pediatric respite care program) that has the primary function of providing certain services, such as skilled nursing care and physical therapy, to a patient at a place of residence used as the patient's home.

Continuing law specifies various databases that are to be checked as part of a database review. The ODH Director is permitted to specify additional databases in rules. The Excluded Parties List System is one of the databases specified in statute. It is maintained by the U.S. General Services Administration. The bill specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.

Women, Infants, and Children (WIC) vendor contracts

(R.C. 3701.132)



In Ohio, ODH administers the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The bill requires ODH to review and process an application for a new contract to act as a WIC vendor not later than 45 days after it is received if on that date the applicant has a contract with ODH to act as a WIC vendor.

