



**S.B. 221**

125th General Assembly  
(As Introduced)

**Sens. Carey, Wachtmann, Goodman, Fingerhut, Fedor, Miller**

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**BILL SUMMARY**

- Requires the Department of Aging to develop a Long-term Care Consultation Program under which residents and potential residents of nursing facilities are provided with information about options available to meet long-term care needs and about factors to consider in making long-term care decisions.
- Modifies the authority of the Department of Job and Family Services (ODJFS) to perform assessments of applicants for or recipients of Medicaid who apply or intend to apply for admission to a nursing facility to determine whether the applicant or recipient needs the level of care provided by such a facility.
- Requires ODJFS to identify options that may be used under the Medicaid Program for financing a system of long-term care services whereby all or part of the amount the Program would incur for care provided to an individual in a nursing facility may follow the individual to various settings according to the individual's needs and preferences, including preferences for home and community-based services, and requires the Director of Job and Family Services to convene a task force to review these options.

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## CONTENT AND OPERATION

### Long-term care assessments

#### Background and overview

Current law provides for several different types of assessments of persons applying or intending to apply for admission to a nursing facility.<sup>1</sup> The Department of Job and Family Services (ODJFS), or an agency designated by the Department, is authorized to assess non-Medicaid recipients who apply or intend to apply to a nursing facility to determine whether the person is in need of nursing facility services and whether an alternative source of long-term care is more appropriate for the person in meeting the person's physical, mental, and psychosocial needs than admission to the facility to which the person has applied (R.C. 5101.75 to 5101.753). In addition, ODJFS may require an applicant for or recipient of Medicaid who applies or intends to apply for admission to a nursing facility to undergo an assessment to determine whether the person needs the level of care provided by a nursing facility (R.C. 5101.754, 5111.204, and 5111.205).

The Department of Mental Health is required to determine--in accordance with federal law--whether a mentally ill individual seeking admission to a nursing facility requires the level of services provided by a nursing facility and, if the individual requires that level of services, whether the individual requires specialized services for mental illness (R.C. 5111.202 and 5119.061). And the Department of Mental Retardation and Developmental Disabilities must make a similar determination with respect to a mentally retarded individual seeking admission to a nursing facility (R.C. 5123.021).

In general, the bill transfers, from ODJFS to the Department of Aging, the authority to perform assessments of non-Medicaid recipients, modifies the nature of those assessments by including a "long-term care consultation," and expands the population that must be given the assessments (R.C. 173.42 and 173.43; R.C. 5101.751 and 5101.753--repealed). It also revises the law governing assessments of Medicaid recipients by ODJFS (R.C. 5111.204; R.C. 5101.754 and 5111.205--repealed).

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<sup>1</sup> "Nursing facility" is defined as a facility, or a distinct part of a facility, that is certified as a nursing facility by the Director of Health in accordance with Title XIX of the Social Security Act and is not an intermediate care facility for the mentally retarded (R.C. 173.42(A)(3) and 5111.20(M)).

**Long-term care consultations by Department of Aging**

(R.C. 173.42(B))

Under the bill, the Department of Aging is required to develop a Long-term Care Consultation Program whereby individuals or their representatives are provided with information through professional consultations about options available to meet long-term care needs and about factors to consider in making long-term care decisions. The Department may enter into a contract with an area agency on aging or other entity under which the long-term care consultation program for a particular area is administered by the area agency on aging or other entity pursuant to the contract; otherwise, the program is to be administered by the Department.

**Information to be provided; assessment of individual's functional capabilities** (R.C. 173.42(D), (E), and (I)). The information provided through a long-term care consultation must be current, accurate, and appropriate to the individual's needs and situation. The information must address the following:

- (1) The availability of any long-term care options open to the individual;
- (2) Sources and methods of both public and private payment for long-term care services;
- (3) Factors to consider when choosing among the available programs, services, and benefits, including cost, quality outcomes, the Estate Recovery Program operated under the Medicaid Law, and compatibility with the individual's preferred lifestyle and residential setting;
- (4) Opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends, and community.

An individual's long-term care consultation may include an assessment of the individual's functional capabilities. It may incorporate portions of the determinations required to be made by the Department of Mental Health or the Department of Mental Retardation and Developmental Disabilities, as described above, and may be performed concurrently with the assessment required to be made by ODJFS (see "**Assessment of Medicaid recipients by ODJFS**," below).

At the conclusion of a consultation, the Department of Aging or the program administrator under contract with the Department must provide the individual or the individual's representative with a written summary of options and resources available to meet the individual's needs. Even though the summary may specify that a source of long-term care other than care in a nursing facility is

appropriate and available, the individual is not required to seek an alternative source and may be admitted to or continue to reside in a nursing facility.

**Individuals to be provided consultations; exemptions** (R.C. 173.42(F) and (H)). Long-term care consultations *must* be performed for (1) individuals who apply or indicate an intention to apply for admission to a nursing facility, regardless of the source of payment to be used for such care, and (2) residents of nursing facilities who apply or indicate an intention to apply for Medicaid.

A long-term care consultation *may* be performed for nursing facility residents who have not applied and have not indicated an intention to apply for Medicaid. The purpose of these consultations is to determine continued need for nursing facility services, to provide information on alternative services, and to make referrals to alternative services.

An individual is not required to be given a long-term care consultation if any of the following apply:

(1) The individual or the individual's representative chooses to forego participation in the consultation pursuant to criteria specified in rules adopted under the bill.

(2) The individual is to receive care in a nursing facility under a contract for continuing care.<sup>2</sup>

(3) The individual has a contractual right to admission to a nursing facility operated as part of a system of continuing care in conjunction with one or more facilities that provide a less intensive level of services, including a residential care facility, an adult care facility, or an independent living arrangement.

(4) The individual is to receive continual care in a home for the aged exempt from taxation.

(5) The individual is seeking admission to a facility that is not a nursing facility with a provider agreement under the Medicaid Law.

(6) The individual is to be transferred from another nursing facility.

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<sup>2</sup> "Continuing care" means the provision of board, lodging, medical services, nursing, and other health-related services to a person 60 years of age or older, unrelated by consanguinity or affinity to the provider, for the life of the person or for a period in excess of one year in return for the payment of an entrance fee or of periodic charges (R.C. 173.13(A)(1)).

(7) The individual is to be readmitted to a nursing facility following a period of hospitalization.

(8) The individual is exempted from the long-term care consultation requirement by the Department of Aging or the program administrator pursuant to rules adopted under the bill.

**Time frame for completion of consultations** (R.C. 173.42(G)). When a long-term care consultation is required to be performed under the bill, it must be performed as follows:

(1) If the individual for whom the consultation is being performed has applied for Medicaid and the consultation is being performed concurrently with the assessment required to be made by ODJFS (see "**Assessment of Medicaid recipients by ODJFS**," below), the consultation must be completed in accordance with the applicable time frames specified in the Medicaid Law for providing a level of care determination based on the assessment.

(2) In all other cases, the consultation must be performed not later than five calendar days after the Department of Aging, or the program administrator under contract with the Department, receives notice that (a) the individual has applied or has indicated an intention to apply for admission to a nursing facility or (b) if the individual is a resident of a nursing facility, the individual has applied or has indicated an intention to apply for Medicaid.

An individual or the individual's representative may request that a long-term care consultation be performed on a date that is later than that required under (1) or (2), above. Additionally, if a consultation cannot be completed within the required time frames, the Department or the program administrator may (a) exempt the individual from the consultation pursuant to rules adopted under the bill, (b) in the case of an applicant for admission to a nursing facility, perform the consultation after the individual is admitted to the facility, or (c) in the case of a resident of a nursing facility, perform the consultation as soon as practicable.

**Who may perform assessments** (R.C. 173.42(C) and 173.43). The long-term care consultations are to be performed by individuals certified by the Department of Aging. The Director of Aging is required to adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) governing the certification process and requirements. The rules must specify the education, experience, or training in long-term care a person is to have to qualify for certification.

**Authority to fine nursing facilities** (R.C. 173.42(J) and (L) and 5111.62). The bill--in a manner similar to existing law--prohibits any nursing facility for

which an operator has a provider agreement under the Medicaid Law from admitting or retaining any individual as a resident, unless the nursing facility has received evidence that a long-term care consultation has been completed for the individual or that the individual is exempt from the long-term care consultation requirement. The Director is permitted to fine a nursing facility an amount determined by rule if the facility violates this prohibition. All fines collected are to be deposited into the state treasury to the credit of the Residents Protection Fund established under current law.

**Rulemaking** (R.C. 173.42(K)). The Director of Aging is authorized by the bill to adopt any rules the Director considers necessary for the implementation and administration of this provision. The rules are to be adopted in accordance with the Administrative Procedure Act and may specify (1) procedures for performing long-term care consultations, (2) information to be provided through long-term care consultations regarding long-term care services that are available, (3) criteria for identifying nursing facility residents who would benefit from long-term care consultations, (4) criteria under which an individual or the individual's representative may choose to forego participation in a long-term care consultation, and (5) criteria for exempting individuals from the long-term care consultation requirement.

**Assessment of Medicaid recipients by ODJFS**

(R.C. 5111.204)

As mentioned above, ODJFS is authorized under current law to require an applicant for or recipient of Medicaid who applies or intends to apply for admission to a nursing facility to undergo an assessment to determine whether the applicant or recipient needs the level of care provided by a nursing facility. The bill modifies this authority in several respects.

**Individuals to be assessed** (R.C. 5111.204(B)). Under the bill, ODJFS is permitted to require *each* applicant for or recipient of Medicaid "who applies for admission to a nursing facility or resides in a nursing facility" to undergo the assessment. The bill specifies that the assessment may be performed concurrently with a long-term care consultation performed by the Department of Aging.

**Who may perform assessments** (R.C. 5111.204(G); R.C. 5101.754--repealed). Current law permits ODJFS to designate another agency to conduct the assessments. The bill instead permits ODJFS to enter into contracts in the form of interagency agreements with one or more other state agencies to perform the assessments. The interagency agreements are to specify the responsibilities of each agency in the performance of the assessments.

**Time frame for making a level of care determination; appeals** (R.C. 5111.204(B) to (D)). The bill requires ODJFS or the agency under contract with the Department, whichever performs the assessment, to give written notice of its conclusions and the basis for them (that is, the "level of care determination") to the person being assessed and the person's representative, if applicable, as follows:

(1) In the case of a person applying for admission to a nursing facility while hospitalized, not later than (a) one working day after the person or the person's representative submits an application for Medicaid and all information needed to perform the assessment and provide the level of care determination or (b) a later date requested by the person or the person's representative.

(2) In the case of an emergency, as determined in accordance with rules adopted under the bill, within the number of days specified in the rules.

(3) In all other cases, regardless of whether the person is applying for admission to a nursing facility or resides in a nursing facility, not later than (a) five calendar days after the person or the person's representative submits an application for Medicaid and all information needed to perform the assessment and provide the level of care determination or (b) a later date requested by the person or the person's representative.

The bill retains the current law provision that permits a person assessed or the person's representative to request a state hearing to dispute the conclusions reached by ODJFS or the agency under contract with the Department on the basis of the assessment. But it specifies that, if a state hearing is requested, the state is to be represented in the hearing by ODJFS or the agency under contract with the Department, whichever performed the assessment.

**Rulemaking; partial assessments eliminated** (R.C. 5111.204(C) and (F)). Current law authorizes the Director of Job and Family Services to adopt rules in accordance with the Administrative Procedure Act to implement and administer the assessment provision. In addition to making conforming changes, the bill eliminates the requirement that the rules set forth circumstances under which ODJFS may perform a "partial assessment." And it adds the requirement that the rules set forth circumstances that constitute an "emergency" and the number of days within which a level of care determination must be provided in the case of an emergency.

**"Money follows the person"; task force**

(R.C. 5111.88 and 5111.881; Section 3)

The bill requires ODJFS to identify options that may be used under the Medicaid Program for financing a system of long-term care services whereby all or part of the amount the Program would incur for care provided to an individual in a nursing facility may follow the individual to various settings according to the individual's needs and preferences, including preferences for home and community-based services.<sup>3</sup> It also requires the Director of Job and Family Services to convene a task force to review these options. The task force is to consist of the Directors of Job and Family Services, Aging, Alcohol and Drug Addiction Services, Budget and Management, Health, Mental Health, and Mental Retardation and Developmental Disabilities.

The task force is to complete its review not later than 180 days after the bill's effective date. Not later than 90 days after completing its review, the task force must prepare a report of its findings and recommendations and submit a copy of that report to the President and Minority Leader of the Senate and to the Speaker and Minority Leader of the House of Representatives.

The Director of Job and Family Services may implement any of the options that are so identified and establish eligibility criteria for participation. The bill authorizes the Director to adopt, in accordance with the Administrative Procedure Act, any rules the Director considers necessary for this purpose.

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**HISTORY**

ACTION	DATE	JOURNAL ENTRY
Introduced	04-06-04	p. 1711

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<sup>3</sup> *The bill states that this requirement is in addition to the Ohio Access Success Project that may be implemented under existing R.C. 5111.88.*