As Introduced

129th General Assembly
Regular Session **S. B. No. 87**
2011-2012

Senators Tavares, Schiavoni

Cosponsor: Senator Skindell

A B I L L

To amend sections 122.63, 5111.16, 5111.85, 5111.861, 5111.89, and 5111.891 and to enact sections 175.14, 2305.2310, 5111.161, 5111.862, and 5111.895 of the Revised Code to implement recommendations of the Unified Long-Term Care Budget Workgroup.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 122.63, 5111.16, 5111.85, 5111.861, 5111.89, and 5111.891 be amended and sections 175.14, 2305.2310, 5111.161, 5111.862, and 5111.895 of the Revised Code be enacted to read as follows:

Sec. 122.63. The department of development shall:

(A) Provide technical assistance to sponsors, homeowners, private developers, contractors, and other appropriate persons on matters relating to housing needs and the development, construction, financing, operation, management, and evaluation of housing developments;

(B) Carry out continuing studies and analyses of the housing needs of this state and, after conducting public hearings, prepare annually a plan of housing needs, primarily for the use of the

department. The plan, copies of which shall be filed with the speaker of the house of representatives and the president of the senate for distribution to the members of the general assembly, shall:

(1) Establish areawide housing needs, including existing and projected needs for the provision of an adequate supply of decent, safe, and sanitary housing for low- and moderate-income persons, including housing that may require utilization of state or federal assistance;

(2) Establish priorities for housing needs, taking into account the availability of and need for conserving land and other natural resources;

(3) Be coordinated with other housing and related planning of the state and of regional planning agencies.

(C) Carry out the provisions of Chapter 3735. of the Revised Code relating to metropolitan housing authorities;

(D) Carry out the provisions of sections 174.01 to 174.07 of the Revised Code relating to the low- and moderate-income housing trust fund;

(E) Request a waiver from the federal government in order to implement a pilot program that would instruct public housing agencies operating under Part IX of Title 24 of the Code of Federal Regulations to give priority to finding housing to individuals who are transitioning from a long-term care facility, as defined in section 175.14 of the Revised Code, or who are at risk of immediate admission to such a long-term care facility.

Sec. 175.14. (A) As used in this section, "long-term care facility" means all of the following:

(1) A nursing home licensed under section 3721.02 or 3721.09 of the Revised Code;

(2) A county home or district home operated under Chapter 5155. of the Revised Code;

(3) A county nursing home as defined in section 5155.31 of the Revised Code.

(B) The Ohio housing finance agency, in providing rental, homeownership, and program assistance, shall adopt a mechanism to give priority to placing and aiding individuals who are transitioning from a long-term care facility or who are at risk of immediate admission to a long-term care facility.

Sec. 2305.2310. (A) As used in this section:

"Community-based long-term care services" and "recipient" have the same meanings as in section 173.14 of the Revised Code.

"Volunteer" means an individual who provides a service without the expectation of receiving and without receipt of any compensation or other form of remuneration from any person or governmental entity.

(B) An individual is not liable in a civil action for damage resulting from conveying in a motor vehicle, as a volunteer, a recipient pursuant to a transportation service included in a community-based long-term care service, unless the individual's action that causes the damage constitutes willful or wanton misconduct.

Sec. 5111.16. (A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

(B) The department shall implement the care management system

in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall implement the care management system in all counties. ~~All~~ Except as provided in division (C) of this section, all individuals included in the category shall be designated for participation~~, except for the individuals specified in divisions (B)(2)(a) to (e) of this section~~. The department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

~~In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following:~~

~~(a) Individuals who are under twenty-one years of age;~~

~~(b) Individuals who are institutionalized;~~

~~(c) Individuals who become eligible for medicaid by spending~~

~~down their income or resources to a level that meets the medicaid program's financial eligibility requirements;~~

~~(d) Individuals who are dually eligible under the medicaid program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;~~

~~(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.~~

(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.

(C) In designating participants who receive medicaid on the basis of being aged, blind, or disabled for participation in the care management system, the department shall not include, except as provided in section 5111.161 of the Revised Code, any of the following:

(1) Individuals who are under twenty-one years of age;

(2) Individuals who are institutionalized;

(3) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(4) Individuals who are dually eligible under the medicaid program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as

amended;

(5) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.

(D) Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code.

~~(D)~~(E)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:

(a) The required designation of participants included in the category identified by the department as covered families and children;

(b) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients;

(c) The use of any programs for enhanced care management.

(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.

~~(E)~~(F) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.161. (A) As used in this section:

"Full-benefit dual eligible individual" has the same meaning as in section 1935(c)(6) of the "Social Security Act," 117 Stat. 2157 (2003), 42 U.S.C. 1396u-5(c)(6), as amended.

"Specialized MA plan for special needs individuals" has the same meaning as in section 1859(b)(6)(A) of the "Social Security Act," 117 Stat. 2207 (2003), 42 U.S.C. 1395w-28(b)(6)(A), as amended.

"Unified long-term care budget workgroup" means the workgroup created by Section 209.40 of Am. Sub. H.B. 1 of the 128th general assembly or a successor to that workgroup.

(B) In addition to designating individuals for participation in the care management system in accordance with division (B) of section 5111.16 of the Revised Code and subject to division (D) of this section, the department of job and family services shall permit an individual to participate in the care management system if all of the following apply:

(1) The individual receives medicaid on the basis of being aged, blind, or disabled.

(2) The individual is a full-benefit dual eligible individual.

(3) The individual is enrolled in a specialized MA plan for special needs individuals.

(4) The individual volunteers to participate in the care management system.

(C) In permitting an individual to participate in the care management system pursuant to division (B) of this section, the department shall do both of the following:

(1) Arrange for the individual to enroll in a health insuring corporation that is under contract with the department pursuant to section 5111.17 of the Revised Code to provide, or arrange for the

provision of, health care services that the individual receives under medicaid;

(2) Take into consideration the recommendations of the unified long-term care budget workgroup concerning the integration of full-benefit dual eligible individuals into the care management system.

(D) The department shall not implement this section until receiving a waiver sought under division (A) of section 5111.16 of the Revised Code if implementation of this section would otherwise violate a federal medicaid requirement.

Sec. 5111.85. (A) As used in this section and sections 5111.851 to 5111.856 of the Revised Code:

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital, nursing facility, or intermediate care facility for the mentally retarded services.

"Hospital" has the same meaning as in section 3727.01 of the Revised Code.

"Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under section 1115 or 1915 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1315 or 1396n. "Medicaid waiver component" does not include a care management system established under section 5111.16 of the Revised Code.

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(B) The director of job and family services may adopt rules under Chapter 119. of the Revised Code governing medicaid waiver components that establish all of the following:

(1) Eligibility requirements for the medicaid waiver components;

(2) The type, amount, duration, and scope of services the medicaid waiver components provide;

(3) The conditions under which the medicaid waiver components cover services;

(4) The amount the medicaid waiver components pay for services or the method by which the amount is determined;

(5) The manner in which the medicaid waiver components pay for services;

(6) Safeguards for the health and welfare of medicaid recipients receiving services under a medicaid waiver component;

(7) Procedures for both of the following:

(a) Identifying individuals who meet all of the following requirements:

(i) Are eligible for a home and community-based services medicaid waiver component and on a waiting list for the component;

(ii) Are receiving inpatient hospital services or residing in an intermediate care facility for the mentally retarded or nursing facility (as appropriate for the component);

(iii) Choose to be enrolled in the component.

(b) Approving the enrollment of individuals identified under the procedures established under division (B)(7)(a) of this section into the home and community-based services medicaid waiver component.

(8) Procedures for enforcing the rules, including

establishing corrective action plans for, and imposing financial and administrative sanctions on, persons and government entities that violate the rules. Sanctions shall include terminating medicaid provider agreements. The procedures shall include due process protections.

(9) Other policies necessary for the efficient administration of the medicaid waiver components.

(C) The director of job and family services may adopt different rules for the different medicaid waiver components. The rules shall be consistent with the terms of the waiver authorizing the medicaid waiver component.

(D) ~~Any~~ The following apply to procedures established under division (B)(7) of this section:

(1) Any such procedures established for the PASSPORT program shall be consistent with section 173.401 of the Revised Code. ~~Any~~

(2) Any such procedures established for Ohio home care shall be consistent with section 5111.862 of the Revised Code.

(3) Any such procedures established ~~under division (B)(7) of this section~~ for the assisted living program shall be consistent with section 5111.894 of the Revised Code.

Sec. 5111.861. (A) As used in this section:

(1) "Assisted living program" means the medicaid waiver component created under section 5111.89 of the Revised Code.

(2) "Choices program" means the medicaid waiver component created under section 173.403 of the Revised Code.

(3) "Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(4) "PASSPORT program" means the medicaid waiver component created under section 173.40 of the Revised Code.

(B) The director of job and family services shall submit a request to the United States secretary of health and human services pursuant to 42 U.S.C. 1396n to obtain a federal medicaid waiver that consolidates the following medicaid waiver components into one medicaid waiver component:

(1) The assisted living program;

(2) The choices program;

(3) The PASSPORT program.

(C) In seeking a consolidated federal medicaid waiver under this section, the director of job and family services shall work with the director of aging and provide for the waiver to do all of the following:

(1) For the part of the waiver that concerns the assisted living program, include the provisions that sections 5111.89 to ~~5111.894~~ 5111.895 of the Revised Code establish for the assisted living program;

(2) For the part of the waiver that concerns the choices program, include the provisions that section 173.403 of the Revised Code establish for the choices program;

(3) For the part of the waiver that concerns the PASSPORT program, include the provisions that sections 173.40 to 173.402 of the Revised Code establish for the PASSPORT program;

(4) For each part of the waiver, including the part that concerns the choices program, be available statewide.

(D) If the United States secretary approves the consolidated federal medicaid waiver sought under this section, all of the following shall apply:

(1) The department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code for the department of aging to administer the

consolidated federal medicaid waiver, except that the department of job and family services, rather than the department of aging, shall administer the part of the waiver that concerns the assisted living program if the director of budget and management does not approve the contract;

(2) The director of job and family services shall adopt rules under section 5111.85 of the Revised Code to authorize the director of aging to adopt rules in accordance with Chapter 119. of the Revised Code that are needed to implement the consolidated federal medicaid waiver, except that the director of job and family services shall adopt rules under section 5111.85 of the Revised Code that are needed to implement the part of the waiver that concerns the assisted living program if the director of budget and management does not approve the contract the departments of job and family services and aging enter into under division (D)(1) of this section;

(3) Any statutory reference to the assisted living program shall mean the part of the consolidated federal medicaid waiver that concerns the assisted living program;

(4) Any statutory reference to the choices program shall mean the part of the consolidated federal medicaid waiver that concerns the choices program;

(5) Any statutory references to the PASSPORT program shall mean the part of the consolidated federal medicaid waiver that concerns the PASSPORT program.

Sec. 5111.862. (A) As used in this section:

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

"Ohio home care" means the medicaid waiver component, as defined in section 5111.85 of the Revised Code, that is known as

Ohio home care and is administered by the department of job and family services pursuant to a waiver granted by the United States secretary of health and human services under section 1915(c) of the "Social Security Act," 95 Stat. 812 (1981), 42 U.S.C. 1396n(c), as amended.

(B) The department of job and family services shall establish a home first component of Ohio home care under which eligible individuals may be enrolled in Ohio home care in accordance with this section. An individual is eligible for Ohio home care's home first component if all of the following apply:

(1) The individual is eligible for Ohio home care.

(2) The individual is on a waiting list for Ohio home care.

(3) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

(b) A physician has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as Ohio home care, will require the individual to be admitted to a nursing facility within thirty days of the physician's determination.

(c) The individual has been hospitalized and a physician has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as Ohio home care, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(C) Each month, each county department of job and family services shall identify individuals residing in the county that the county department serves who are eligible for the home first component of Ohio home care. When a county department identifies such an individual, the county department shall determine whether Ohio home care is appropriate for the individual and whether the

individual would rather participate in Ohio home care than continue or begin to reside in a nursing facility. If the county department determines that Ohio home care is appropriate for the individual and the individual would rather participate in Ohio home care than continue or begin to reside in a nursing facility, the county department shall so notify the state department of job and family services. On receipt of the notice from the county department, the state department shall approve the individual's enrollment in Ohio home care regardless of the waiting list for Ohio home care, unless the enrollment would cause Ohio home care to exceed any limit on the number of individuals who may be enrolled in the waiver as set by the United States secretary of health and human services in the waiver authorizing Ohio home care.

(D) Each quarter, the state department of job and family services shall certify to the director of budget and management the estimated increase in costs of Ohio home care resulting from enrollment of individuals in Ohio home care pursuant to this section.

Sec. 5111.89. (A) As used in sections 5111.89 to ~~5111.894~~ 5111.895 of the Revised Code:

"Area agency on aging" has the same meaning as in section 173.14 of the Revised Code.

"Assisted living program" means the program created under this section.

"Assisted living services" means the following home and community-based services: personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic social and recreational programming.

"County or district home" means a county or district home

operated under Chapter 5155. of the Revised Code.

"Long-term care consultation program" means the program the department of aging is required to develop under section 173.42 of the Revised Code.

"Long-term care consultation program administrator" or "administrator" means the department of aging or, if the department contracts with an area agency on aging or other entity to administer the long-term care consultation program for a particular area, that agency or entity.

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

"Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

"State administrative agency" means the department of job and family services if the department of job and family services administers the assisted living program or the department of aging if the department of aging administers the assisted living program.

(B) There is hereby created the assisted living program. The program shall provide assisted living services to individuals who meet the program's eligibility requirements established under section 5111.891 of the Revised Code. The program may not serve more individuals than the number that is set by the United States secretary of health and human services when the medicaid waiver authorizing the program is approved. The program shall be operated as a separate medicaid waiver component until the United States secretary approves the consolidated federal medicaid waiver sought under section 5111.861 of the Revised Code. The program shall be part of the consolidated federal medicaid waiver sought under that

section if the United States secretary approves the waiver.

If the director of budget and management approves the contract, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code that provides for the department of aging to administer the assisted living program. The contract shall include an estimate of the program's costs.

The director of job and family services may adopt rules under section 5111.85 of the Revised Code regarding the assisted living program. The director of aging may adopt rules under Chapter 119. of the Revised Code regarding the program that the rules adopted by the director of job and family services authorize the director of aging to adopt.

Sec. 5111.891. To be eligible for the assisted living program, an individual must meet all of the following requirements:

(A) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

(B) ~~At the time the individual applies for the assisted living program, be one of the following:~~

~~(1) A nursing facility resident who is seeking to move to a residential care facility and would remain in a nursing facility for long term care if not for the assisted living program;~~

~~(2) A participant of any of the following medicaid waiver components who would move to a nursing facility if not for the assisted living program:~~

~~(a) The PASSPORT program created under section 173.40 of the Revised Code;~~

~~(b) The choices program created under section 173.403 of the Revised Code;~~

~~(c) A medicaid waiver component that the department of job and family services administers.~~

~~(3) A resident of a residential care facility who has resided in a residential care facility for at least six months immediately before the date the individual applies for the assisted living program.~~

~~(C)~~ At the time the individual receives assisted living services under the assisted living program, reside in a residential care facility that is authorized by a valid medicaid provider agreement to participate in the assisted living program, including both of the following:

(1) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;

(2) A county or district home licensed as a residential care facility.

~~(D)~~(C) Meet all other eligibility requirements for the assisted living program established in rules adopted under section 5111.85 of the Revised Code.

Sec. 5111.895. The state administrative agency shall establish a presumptive eligibility process for the assisted living program. Under the presumptive eligibility process, an individual may be enrolled conditionally in the assisted living program before the individual is determined to meet the program's financial eligibility requirements established in rules authorized by division (C) of section 5111.891 of the Revised Code if both of the following apply:

(A) A written plan of care or individual service plan has

been created for the individual pursuant to division (B)(3) of section 5111.851 of the Revised Code.

(B) The individual has been determined to meet both of the following:

(1) The eligibility requirements established by divisions (A) and (B) of section 5111.891 of the Revised Code;

(2) The eligibility requirements established in rules authorized by division (C) of section 5111.891 of the Revised Code other than such eligibility requirements that are financial eligibility requirements.

Section 2. That existing sections 122.63, 5111.16, 5111.85, 5111.861, 5111.89, and 5111.891 of the Revised Code are hereby repealed.

Section 3. (A) Not later than ninety days after the effective date of this section, the Director of Job and Family Services shall submit a state Medicaid plan amendment or Medicaid waiver request to the United States Secretary of Health and Human Services as necessary to obtain federal financial participation for a pilot program to be operated under this section. Not later than ninety days after the date the United States Secretary approves the plan amendment or waiver, the Department of Job and Family Services shall contract with the Department of Mental Health pursuant to section 5111.91 of the Revised Code to have the Department of Mental Health operate the pilot program for two years. The purpose of the pilot program is to assist Medicaid recipients who have severe mental illnesses and reside in nursing facilities transition to home or community-based services. The Director of Job and Family Services may adopt rules under section 5111.011 or 5111.85 of the Revised Code establishing additional eligibility requirements for the pilot program. To the extent

possible, the pilot program shall be modeled after the Money Follows the Person demonstration project authorized by Section 6071 of the "Deficit Reduction Act of 2005," 120 Stat. 102, as amended.

(B) In operating the pilot program, the Department of Mental Health shall provide for a technical assistance advisor to do both of the following:

(1) Design and implement a training course for individuals who assist Medicaid recipients transition to home or community-based services under the pilot program;

(2) Provide technical assistance to both of the following:

(a) Medicaid recipients seeking to transition to home or community-based services under the pilot program;

(b) Individuals who assist Medicaid recipients transition to home or community-based services under the pilot program.

(C) The Departments of Mental Health and Job and Family Services shall prepare and complete a report on the pilot program not later than one year after the pilot program ceases operation. On completion of the report, the Departments shall submit the report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly.

Section 4. The Department of Job and Family Services, in consultation with the Department of Aging, shall study the issue of providing care coordination for the acute benefits provided under home and community-based services Medicaid waiver components as defined in section 5111.85 of the Revised Code. Not later than one year after the effective date of this section, the Departments shall submit a report regarding their study to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly.

Section 5. The Department of Aging shall study the issue of credentialing or licensing discharge planners employed by nursing homes and hospitals. In conducting the study, the Department shall examine the qualifications, including educational qualifications, that a discharge planner should have to be credentialed or licensed. Not later than one year after the effective date of this section, the Department shall submit a report regarding its study to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly. The report shall include recommendations regarding the credentialing or licensing of discharge planners employed by nursing homes and hospitals.