As Passed by the House

134th General Assembly

Regular Session **Am. Sub. S. B. No. 160**

2021-2022

Senator O'Brien

Cosponsors: Senators Cirino, Schaffer, Hackett, Hoagland, Johnson, Fedor, Antonio, Blessing, Brenner, Craig, Dolan, Gavarone, Huffman, S., Kunze, Lang, Maharath, Manning, McColley, Peterson, Reineke, Roegner, Romanchuk, Rulli, Schuring, Sykes, Thomas, Williams, Wilson, Yuko Representatives Baldridge, Blackshear, Brent, Brown, Carruthers, Click, Creech, Crossman, Denson, Edwards, Fowler Arthur, Fraizer, Galonski, Ghanbari, Ginter, Grendell, Gross, Hall, Hicks-Hudson, Holmes, Hoops, Humphrey, Jarrells, John, Johnson, Jones, Kick, Koehler, Lampton, LaRe, Leland, Lepore-Hagan, Lipps, Liston, Loychik, Manning, Miller, A., Miller, J., Miller, K., Miranda, Oelslager, Patton, Pavliga, Plummer, Richardson, Roemer, Russo, Schmidt, Smith, M., Sobecki, Stein, Stephens, Stevens, Stewart, Swearingen, Troy, Upchurch, Weinstein, West, Wilkin, Young, T., Speaker Cupp

A BILL

To amend sections 173.42, 3712.06, and 3727.75 and to enact sections 3721.141 and 5162.75 of the Revised Code to require certain entities to inform veterans and their spouses about available health care benefits, to require the Department of Medicaid to inform a veteran who applies for Medicaid about the county veterans service commission, and to name this act the Veteran Information Act.

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

Section 1. That sections 173.42, 3712.06, and 3727.75 be amended and sections 3721.141 and 5162.75 of the Revised Code be

enacted to read as follows:

Sec. 173.42. (A) As used in sections 173.42 to 173.434 of the Revised Code:

(1) "Area agency on aging" means a public or private nonprofit entity designated under section 173.011 of the Revised Code to administer programs on behalf of the department of aging.

(2) "Department of aging-administered medicaid waiver component" means each of the following:

(a) The medicaid-funded component of the PASSPORT program created under section 173.52 of the Revised Code;

(b) The medicaid-funded component of the assisted living program created under section 173.54 of the Revised Code;

(c) Any other medicaid waiver component, as defined in section 5166.01 of the Revised Code, that the department of aging administers pursuant to an interagency agreement with the department of medicaid under section 5162.35 of the Revised Code.

(3) "Home and community-based services covered by medicaid components the department of aging administers" means all of the following:

(a) Medicaid waiver services available to a participant in a department of aging-administered medicaid waiver component;

(b) The following medicaid state plan services available to a participant in a department of aging-administered medicaid waiver component as specified in rules adopted under section 5164.02 of the Revised Code:

(i) Home health services;

(ii) Private duty nursing services;

(iii) Durable medical equipment;

(iv) Services of a clinical nurse specialist;

(v) Services of a certified nurse practitioner.

(c) Services available to a participant of the PACE program.

(4) "Long-term care consultation" or "consultation" means the consultation service made available by the department of aging or a program administrator through the long-term care consultation program established pursuant to this section.

(5) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

(6) "PACE program" means the component of the medicaid program the department of aging administers pursuant to section 173.50 of the Revised Code.

(7) "PASSPORT administrative agency" means an entity under contract with the department of aging to provide administrative services regarding the PASSPORT program.

(8) "Program administrator" means an area agency on aging or other entity under contract with the department of aging to administer the long-term care consultation program in a geographic region specified in the contract.

(9) "Representative" means a person acting on behalf of an individual who is the subject of a long-term care consultation. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of

the individual.

(B) The department of aging shall develop a long-term care consultation program whereby individuals or their representatives are provided with long-term care consultations and receive through these professional consultations information about options available to meet long-term care needs and information about factors to consider in making long-term care decisions. The long-term care consultations may be provided at any appropriate time, including either prior to or after the individual who is the subject of a consultation has been admitted to a nursing facility or granted assistance in receiving home and community-based services covered by medicaid components the department of aging administers.

(C) The long-term care consultation program shall be administered by the department of aging, except that the department may have the program administered on a regional basis by one or more program administrators. The department and each program administrator shall administer the program in such a manner that all of the following are included:

(1) Coordination and collaboration with respect to all available funding sources for long-term care services;

(2) Assessments of individuals regarding their long-term care service needs;

(3) Assessments of individuals regarding their on-going eligibility for long-term care services;

(4) Procedures for assisting individuals in obtaining access to, and coordination of, health and supportive services, including department of aging-administered medicaid waiver components;

(5) Priorities for using available resources efficiently and effectively.

(D) The program's long-term care consultations shall be provided by individuals certified by the department under section 173.422 of the Revised Code.

(E) The information provided through a long-term care consultation shall be appropriate to the individual's needs and situation and shall address all of 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;

(4) Opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends, and community;

(5) If the individual is a veteran, as defined in section 5901.01 of the Revised Code, or the spouse, surviving spouse, or representative of the veteran, both of the following:

(a) The availability of health care or financial benefits through the United States department of veterans affairs;

(b) Information about congressionally chartered veterans service organizations or the county veterans service office that can assist with investigating and applying for benefits through the United States department of veterans affairs.

(F) An individual's long-term care consultation may

include an assessment of the individual's functional capabilities. The consultation may incorporate portions of the determinations required under sections 5119.40, 5123.021, and 5165.03 of the Revised Code and may be provided concurrently with the assessment required under section 173.546 or 5165.04 of the Revised Code.

(G) Except as provided in division (I) of this section, a long-term care consultation shall be provided to each individual for whom the department or a program administrator determines such a consultation is appropriate.

(H) A long-term care consultation shall be completed within the applicable time frames specified in rules adopted under this section.

(I) An individual is not required to be provided a long-term care consultation if any of the following is the case:

(1) The department or a program administrator has attempted to provide the consultation, but the individual or the individual's representative refuses to cooperate;

(2) The individual is to receive care in a nursing facility under a contract for continuing care, as defined in section 173.13 of the Revised Code;

(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 licensed under Chapter 3721. of the Revised Code, a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults, or

an independent living arrangement;

(4) The individual is to receive continual care in a home for the aged exempt from taxation under section 5701.13 of the Revised Code;

(5) The individual is seeking admission to a facility that is not a nursing facility with a provider agreement under section 5165.07, 5165.511, or 5165.512 of the Revised Code;

(6) Pursuant to rules that may be adopted under this section, the department or a program administrator has exempted the individual from receiving the long-term care consultation.

(J) As part of the long-term care consultation program, the department or a program administrator may assist an individual or individual's representative in accessing all sources of care and services that are appropriate for the individual and for which the individual is eligible, including all available home and community-based services covered by medicaid components the department of aging administers. The assistance may include providing for the conduct of assessments or other evaluations and the development of individualized plans of care or services under section 173.424 of the Revised Code.

(K) No nursing facility for which an operator has a provider agreement under section 5165.07, 5165.511, or 5165.512 of the Revised Code shall admit as a resident any individual described in division (G) of this section, unless the nursing facility has received evidence that a long-term care consultation has been completed for the individual or division (I) of this section is applicable to the individual.

(L) The director of aging shall adopt rules for the implementation and administration of this section. The rules

shall be adopted in accordance with Chapter 119. of the Revised Code. The rules may specify any or all of the following:

(1) Procedures for providing long-term care consultations;

(2) Information to be provided through long-term care consultations regarding long-term care services that are available;

(3) Criteria and procedures to be used to identify and recommend appropriate service options for an individual receiving a long-term care consultation;

(4) Criteria for exempting individuals from receiving a long-term care consultation;

(5) Circumstances under which it may be appropriate to provide an individual's long-term care consultation after the individual's admission to a nursing facility rather than before admission;

(6) Criteria for identifying individuals for whom a long-term care consultation is appropriate, including nursing facility residents who would benefit from the consultation;

(7) A description of the types of information from a nursing facility that is needed under the long-term care consultation program to assist a resident with relocation from the facility;

(8) Standards to prevent conflicts of interest relative to the referrals made by a person who performs a long-term care consultation, including standards that prohibit the person from being employed by a provider of long-term care services;

(9) Procedures for providing notice and an opportunity for a hearing under division (N) of this section;

(10) Time frames for providing or completing a long-term care consultation;

(11) Any other standards or procedures the director considers necessary for the program.

(M) To assist the department and each program administrator with identifying individuals for whom a long-term care consultation is appropriate, the department and program administrator may ask to be given access to nursing facility resident assessment data collected through the use of the resident assessment instrument specified in rules authorized by section 5165.191 of the Revised Code for purposes of the medicaid program. Except when prohibited by state or federal law, the department of health, department of medicaid, or nursing facility holding the data shall grant access to the data on receipt of the request from the department of aging or program administrator.

(N)(1) The director of aging, after providing notice and an opportunity for a hearing, may fine a nursing facility an amount determined by rules the director shall adopt in accordance with Chapter 119. of the Revised Code for any of the following reasons:

(a) The nursing facility violates division (K) of this section;

(b) The nursing facility denies a person attempting to provide a long-term care consultation access to the facility or a resident of the facility;

(c) The nursing facility denies the department of aging or a program administrator access to the facility or a resident of the facility, as the department or administrator considers

necessary to administer the program.

(2) In accordance with section 5162.66 of the Revised Code, all fines collected under division (N)(1) of this section shall be deposited into the state treasury to the credit of the residents protection fund.

Sec. 3712.06. Any person or public agency licensed under section 3712.04 of the Revised Code to provide a hospice care program shall:

(A) Provide a planned and continuous hospice care program, the medical components of which shall be under the direction of a physician;

(B) Ensure that care is available twenty-four hours a day and seven days a week;

(C) Establish an interdisciplinary plan of care for each hospice patient and the patient's family that:

(1) Is coordinated by one designated individual who shall ensure that all components of the plan of care are addressed and implemented;

(2) Addresses maintenance of patient-family participation in decision making; and

(3) Is periodically reviewed by the patient's attending physician and by the patient's interdisciplinary team.

(D) Have an interdisciplinary team or teams that provide or supervise the provision of care and establish the policies governing the provision of the care;

(E) Provide bereavement counseling for hospice patients' families;

(F) Not discontinue care because of a hospice patient's inability to pay for the care;

(G) Maintain central clinical records on all hospice patients under its care; and

(H) Provide care in individuals' homes, on an outpatient basis, and on a short-term inpatient basis.

A provider of a hospice care program may include pharmacist services among the other services that are made available to its hospice patients.

A provider of a hospice care program may arrange for another person or public agency to furnish a component or components of the hospice care program pursuant to a written contract. When a provider of a hospice care program arranges for a hospital, a home providing nursing care, or home health agency to furnish a component or components of the hospice care program to its patient, the care shall be provided by a licensed, certified, or accredited hospital, home providing nursing care, or home health agency pursuant to a written contract under which:

(1) The provider of a hospice care program furnishes to the contractor a copy of the hospice patient's interdisciplinary plan of care that is established under division (C) of this section and specifies the care that is to be furnished by the contractor;

(2) The regimen described in the established plan of care is continued while the hospice patient receives care from the contractor, subject to the patient's needs, and with approval of the coordinator of the interdisciplinary team designated pursuant to division (C)(1) of this section;

(3) All care, treatment, and services furnished by the contractor are entered into the hospice patient's medical record;

(4) The designated coordinator of the interdisciplinary team ensures conformance with the established plan of care; and

(5) A copy of the contractor's medical record and discharge summary is retained as part of the hospice patient's medical record.

Any hospital contracting for inpatient care shall be encouraged to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital.

(I) Notify a veteran, spouse, surviving spouse, or representative on behalf of the veteran, seeking services from the hospice care agency that the veteran, spouse, or surviving spouse, may be eligible for health care or financial benefits through the United States department of veterans affairs and provide the veteran, spouse, surviving spouse, or representative with information about congressionally chartered veterans service organizations or the county veterans service office that can assist with investigating and applying for benefits through the United States department of veterans affairs. As used in this division, "veteran" has the same meaning as in section 5901.01 of the Revised Code.

Sec. 3721.141. (A) As used in this section, "veteran" has the same meaning as in section 5901.01 of the Revised Code.

(B) Each nursing home, except a nursing home that participates in the veteran community partnerships program administered by the United States department of veterans

affairs, and each skilled nursing facility shall provide both of the following to a veteran, spouse, surviving spouse, or representative on behalf of the veteran, seeking admission to the home or facility:

(1) Notification that the veteran, spouse, or surviving spouse may be eligible for health care or financial benefits through the United States department of veterans affairs;

(2) Information about congressionally chartered veterans service organizations or the county veterans service office that can assist with investigating and applying for benefits through the United States department of veterans affairs.

Sec. 3727.75. (A) A hospital that intends to discharge a patient shall, as soon as practicable, create a discharge plan in accordance with state and federal law and hospital policy and review that plan with the patient or the patient's guardian. If a lay caregiver designation has been made, the discharging health care professional has determined that the lay caregiver's participation in the review would be appropriate, and the lay caregiver is available within a reasonable amount of time, the hospital shall arrange for the lay caregiver to also participate in the review. The review shall be conducted in accordance with section 3727.76 of the Revised Code.

(B)(1) A discharge plan may include the following information:

(a) A description of the tasks that are necessary to facilitate the patient's transition from the hospital to the patient's residence;

(b) Contact information for the health care providers or providers of community or long-term care services that the

hospital and the patient or guardian believe are necessary for successful implementation of the discharge plan.

(2) If the patient is a veteran, as defined in section 5901.01 of the Revised Code, who requires additional health care services after discharge, such as through a hospice care program, nursing home, or home care or residential services, a discharge plan shall include both of the following:

(a) Notification that the veteran, spouse, or surviving spouse may be eligible for health care or financial benefits through the United States department of veterans affairs;

(b) Information about congressionally chartered veterans service organizations or the county veterans service office that can assist with investigating and applying for benefits through the United States department of veterans affairs.

(3) If a lay caregiver designation has been made and the discharging health care professional has determined that the lay caregiver is to have a role in the discharge plan, the discharge plan may include any of the following:

(a) The lay caregiver's name, address, telephone number, electronic mail address, and relationship to the patient, if available;

(b) A description of all after-care tasks to be performed by the lay caregiver, taking into account the lay caregiver's capability to perform such tasks;

(c) Any other information the hospital believes is necessary for successful implementation of the discharge plan.

(C) A discharging health care professional shall not be subject to criminal prosecution or professional disciplinary

action, or be liable in a tort action or other civil action, for an event or occurrence that allegedly arises out of the health care professional's determination that a patient's lay caregiver should or should not participate in the review of the patient's discharge plan.

Sec. 5162.75. The medicaid director shall provide, to a veteran who has submitted an application for the medicaid program, information about the county veterans service office that can assist with investigating and applying for benefits through the United States department of veterans affairs. As used in this section, "veteran" has the same meaning as in section 5901.01 of the Revised Code.

Section 2. That existing sections 173.42, 3712.06, and 3727.75 of the Revised Code are hereby repealed.

Section 3. This act shall be known as the Veteran Information Act.