SENATE BILL No. 998

Introduced by Senator Liu

February 9, 2010

An act to add Division 13 (commencing with Section 22100) to the Welfare and Institutions Code, relating to long-term care services.

LEGISLATIVE COUNSEL'S DIGEST

SB 998, as introduced, Liu. Long-term care: assessment and planning.

Existing law provides for the licensure of various health facilities, including general acute care facilities, skilled nursing facilities, and intermediate care facilities, by the State Department of Public Health.

Existing law establishes the California Partnership for Long-Term Care Program and requires the State Department of Health Care Services to adopt regulations to administer the program.

This bill would require the State Department of Health Care Services to initiate a process to develop, by no later than July 1, 2012, a tool for the uniform long-term care services assessment of individuals in order to assist consumers in finding long-term care services of their choice, as specified. The department would be required to submit a report on the use of these assessments to the Legislature. The bill would, commencing July 1, 2012, require, with certain exceptions, every long-term health care facility that receives an application for admission of a Medi-Cal eligible or Medicare/Medi-Cal eligible person to initiate the assessment prior to admission or on the first day for which Medi-Cal reimbursement is requested. It would also require, commencing July 1, 2012, with certain exceptions, every general acute care hospital that identifies a Medi-Cal eligible or Medicare/Medi-Cal eligible person for referral to a long-term health facility to initiate a uniform long-term care services assessment at the time of referral. It would also prohibit, on and after January 1, 2013, any facility that admits a Medi-Cal eligible

or Medicare/Medi-Cal eligible person that has not initiated a required uniform long-term care services assessment within 48 hours of admission from receiving reimbursement until the assessment has been initiated, and from being reimbursed for those days during which assessment could have been initiated, but was not initiated.

This bill would, among other things, require every county department of social services or public health, when it establishes a long-term care case management program, to assign case managers to each acute care hospital, skilled nursing facility, and other licensed long-term care facility located within the county department's jurisdiction. After these facilities are notified of the appropriate case manager, each facility would be required to inform the case manager when a new patient or resident is admitted and that may need specified assistance.

The bill would also require these persons, upon a discharge from a long-term care facility, to be provided with prescribed services by the county, and would express intent pertaining to the funding of these services. Because the bill would impose various duties on each county, the bill would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) California is home to the largest older adult population in the nation. Currently, approximately 4.4 million older adults will comprise almost 15 percent of the state's population. By 2030, projections suggest that 8.3 million older adults will account for nearly 18 percent of the population.

(b) California's services for older adults and other adults with long-term care needs currently exist in an uncoordinated patchwork of programs overseen by multiple state agencies and organizations, rather than a coordinated continuum of care focused on providing

services that are consumer-centered, least restrictive, and most cost effective.

(c) All older adults and other adults with long-term care needs, whether they are residing in a nursing facility or living in the community, should have access to information about the services that are available in order to avoid institutionalization and the services of a counselor or case manager who can help navigate the multiple health and social service programs that may provide benefits to that individual.

(d) Given recent reports and recommendations, California needs a strategic plan for long-term care services that will maximize the use of finite resources and reduce the use of institutional care. California's plan for the implementation of the federal Olmstead decision is the beginning of the process of providing the statewide service coordination and assessment necessary for a continuum of services for those in need of long-term care, including older adults.

(e) The public interest would best be served by a broad array of long-term care services that support persons who need these services at home or in the community whenever practicable, and that promote individual autonomy, dignity, and choice. In-home supportive services and adult day health care are examples of services that the state should prioritize with stable and adequate funding.

(f) Other states that have invested in a coordinated approach for long-term care and home- and community-based services have improved the effectiveness of the overall delivery system and reduced the rate of growth of institutional care.

(g) In order for California to adequately meet the challenges of an aging population and implement the Olmstead decision, it is the intent of the Legislature to establish an integrated system of long-term care that will enable older adults and other adults with long-term care needs to remain at home whenever possible and live in the least restrictive environment with autonomy, dignity, and choice whenever possible.

SEC. 2. Division 13 (commencing with Section 22100) is added to the Welfare and Institutions Code, to read:

DIVISION 13. LONG-TERM CARE ASSESSMENT AND PLANNING FOR INDIVIDUALS

22100. It is the intent of the Legislature to establish a long-term care services system that does all of the following:

(a) Provides a continuum of social and health services that foster independence and self-reliance, maintain individual dignity, and allow consumers of long-term care services to remain an integral part of their family and community life. Essential features of this continuum may include any or all of the following:

(1) Discharge planning in hospitals, skilled nursing facilities, and other licensed care with the goal of returning an individual to his or her home as soon as possible, with support services if necessary. Discharge planning includes both diversion from hospital to home and transition from skilled nursing facility or another residential care setting to home. Discharge planning may begin before a scheduled hospital visit.

(2) The ability to maintain or make modifications on homes necessary for a person to remain or to return.

(3) Budget flexibility within a unified budget for long-term care. This includes funds for nursing facility services, in-home supportive services (IHSS), adult day health care, a multipurpose senior services project (MSSP), waiver programs, and other home- and community-based services.

(4) The integration and expansion of federal waiver programs to realize maximum federal fund participation.

(5) Rental assistance vouchers for those who are able to transfer from an institution, but who have no permanent home.

(6) A common database that is accessible and interoperable across programs enabling the state and counties to combine and analyze data from treatment authorization requests (TARs), in-home supportive services, hospitals, nursing homes, and other facilities and programs.

(b) Ensures that, if out-of-home placement is necessary, it is at the appropriate level of care, and prevents unnecessary utilization of acute care hospitals, skilled nursing facilities, and other licensed residential care facilities.

(c) Delivers long-term care services in the least restrictive environment appropriate for the consumer, based on the consumer's individual needs and choices.

(d) Provides older adults with the information and supports needed to exercise self-direction and to make choices, given those adults capability and interest, and involves them and their family members as partners in the development and implementation of long-term care services.

22101. (a) The State Department of Health Care Services shall initiate a process, in collaboration with stakeholders, to develop no later than July 1, 2012, a tool for the uniform, long-term care services assessment of individuals in order to assist consumers in finding long-term care services of their choice. Stakeholders in this process shall include consumer advocates, advocates for older adults, disability rights advocates, public and private hospitals, long-term care facilities, home health and hospice agencies, long-term care program representatives, including in-home supportive services and county representatives. The uniform long-term care services assessment tool shall be developed to assist consumers make informed choices about home and community options for individuals who are hospitalized and likely to need long-term care, or individuals in the community who are likely to need long-term care. In addition, the department shall, in collaboration with the stakeholders, establish training standards for the use of the uniform long-term care services assessment tool for use by an individual pursuant to Section 22102.

(b) Individuals eligible for the uniform long-term care services assessment tool shall include all of the following:

(1) Medicaid enrollees and recipients, Medicaid applicants, or individuals eligible for both Medicare and Medicaid.

(2) Individuals who apply or are likely to apply for admission to a nursing facility.

(3) Individuals who are reasonably expected to become Medicaid recipients within 180 days of admission to a nursing facility.

(c) In developing the uniform long-term care services assessment tool, the department and stakeholders in the development process shall consider all of the following:

(1) The long-term care programs for which the individual is or may become eligible.

(2) The individual’s strengths, limitations, and preferences.

(3) The individual’s preferred living situation and environment.

(4) The individual’s physical health, and functional and cognitive abilities.

(5) The individual's available informal supports and other paid or unpaid resources.

(6) The individual's need for intervention.

(7) The individual's need for case management activities.

(8) The individual's need for referrals.

(9) The individual's plan of care needs, including all of the following:

(A) Personal care and household assistance needs.

(B) Treatments or therapies, or both.

(C) Medication management.

(D) Seizures.

(E) Skin care.

(F) Preventive care.

(G) Risk of falls.

(H) Pain management.

(I) Cognitive capacity.

(J) Depression.

(K) Problem behaviors.

(L) Suicide risk.

(M) Substance abuse.

(N) Communication.

(O) Family supports and other nonfamilial support systems.

(P) Consumer goals.

(d) The department shall, in collaboration with the stakeholder groups identified in subdivision (a), develop a process by which individuals who receive the uniform long-term care services assessment and express a preference for living appropriately at home or in another community-based setting, also receive all of the following:

(1) A comprehensive community services plan, to be developed with the individual and, as appropriate, the individual's representative.

(2) Information about the availability of services that could meet the individual's needs, as set forth in the community services plan, and an explanation of the cost to the individual of the available in-home and community services in relation to nursing facility care.

(3) Information on retention of Supplemental Security Income/State Supplementary Plan benefits, home modification allowances, or home maintenance allowances, and any other

financial supports that would assist the individual in maintaining his or her home during a hospital or nursing facility stay.

(4) Opportunity for discussion, evaluation, and ongoing involvement with a case manager or counselor.

22102. Any individual employed by the state or by a county may perform the long-term care services assessment if the individual employee has attained a level of training that meets the training standards established in subdivision (a) of Section 22101.

22103. (a) Except as provided in subdivision (c), commencing July 1, 2012, every long-term care facility that receives an application for admission of a Medi-Cal eligible or Medicare/Medi-Cal eligible person shall, using the assessment tool developed pursuant to Section 22101, initiate a uniform long-term care services assessment prior to admission or on the first day for which Medi-Cal reimbursement is requested.

(b) Except as provided in subdivision (c), commencing July 1, 2012, every general acute care hospital, as defined in Section 1250 of the Health and Safety Code, that identifies a Medi-Cal eligible or Medicare/Medi-Cal eligible person for referral to a long-term facility shall initiate a uniform long-term care services assessment at the time of referral.

(c) A uniform long-term care services assessment shall not be required for persons referred to programs for the mentally ill or developmentally disabled administered by the State Department of Mental Health or the State Department of Developmental Services where an assessment is in place for mental health services, development center services, or regional center services.

(d) On and after January 1, 2013, a long-term care facility that admits a Medi-Cal eligible or Medicare/Medi-Cal eligible person and that has not initiated a uniform long-term care services assessment required pursuant to subdivisions (a) and (b) within 48 hours of admission shall not receive reimbursement until the assessment has been initiated, and shall not be reimbursed for those days during which assessment could have been initiated, but was not initiated.

(e) A uniform long-term care services assessment shall be considered initiated when a facility or provider has made a request for the assessment to the county or the appropriate department.

(f) Individuals admitted to a long-term care facility who have been residing in the independent living or residential care facility

portion of a multilevel facility that includes residents of continuing care retirement communities shall be subject to the uniform long-term care services assessment.

(g) By December 1, 2013, the State Department of Health Care Services shall report to the Legislature the total number of long-term care services assessments performed in the state, along with all of the following:

(1) The total number of assessments of individuals from the community.

(2) The total number of assessments of individuals from nursing facilities.

(3) The total number of assessments of individuals from hospitals.

(4) The total number of individuals assessed who were placed in community care.

(5) The total number of individuals assessed who were placed in nursing homes.

(6) The total number of individuals assessed who were diverted from nursing home placement.

(7) The total number of individuals assessed who were not able to be diverted, and why, including, but not limited to, personal choice, medical condition, unavailability of community-based services, such as in-home supportive services, adult day health care, Alzheimer's-specific programs, independent living programs, housing assistance, residential care facilities for the elderly, home-delivered meals, home health care, protective services, respite care, social day care, transportation services, or legal assistance.

(h) (1) The department shall pursue any additional necessary waivers and state plan amendments to ensure federal financial participation in funding increases to home- and community-based services, including, but not limited to, in-home supportive services and adult day health care, home maintenance and home modification allowances, as well as training and employment of individuals who will conduct the uniform long-term care assessments and case management or counseling of individuals eligible or at-risk of needing long-term care.

(2) On or before July 1, 2011, the department shall, in collaboration with stakeholders identified in subdivision (a) of Section 22101, submit to the Legislature a financing plan for

providing long-term care services pursuant to this division. By December 1, 2011, the department shall, in collaboration with stakeholders, submit to the Legislature a proposal for the temporary or permanent restructuring of bed rates and reimbursements to nursing facilities and the redirection of penalties and fines to fund its plan for long-term care services, if necessary.

(3) Subdivisions (g) and (h) shall not be implemented unless the director of the department certifies that the collection of federal funds, other revenue from restructuring of reimbursements, penalties, and fines, or private funds, is sufficient to fund the implementation of long-term care services assessments, case management or counseling, and services pursuant to this division.

(i) The department may, in collaboration with the stakeholders identified in subdivision (a) of Section 22101, evaluate whether existing state or county information systems and processes may be developed to meet the purposes of this division.

(j) For purposes of this section, a long-term care facility includes a skilled nursing facility, intermediate care facility, intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, intermediate care facility/developmentally disabled nursing, and congregate living health facility, as these terms are defined in Section 1250 of the Health and Safety Code.

22104. The Legislature finds and declares all of the following:

(a) A principal purpose of case management is to enable an individual to return home from a hospital following an illness or injury and to return home from a skilled nursing facility or other long-term care facility.

(b) The purpose of case management in discharge planning is to divert an individual who would otherwise enter a skilled nursing facility from a general acute care hospital and to transfer an individual out of a skilled nursing facility when he or she is able to be home or in a less restrictive environment.

(c) If case management for long-term care is to be phased in, then it is the intent of the Legislature for case management to be established as early as possible for persons newly placed in a skilled nursing facility, as defined in Section 1250 of the Health and Safety Code, or other licensed facilities and for patients of a general acute care hospital who may be discharged if certain home- and community-based services are immediately available.

22105. (a) When a county department of social services or public health establishes a long-term care case management program for persons who are eligible for Medi-Cal or Medicare, the county department shall assign case managers to each general acute care hospital, skilled nursing facility, and other licensed long-term care facility located within the department's jurisdiction. After these health facilities are notified of the appropriate case manager, each facility shall inform the case manager of when a new patient or resident is admitted and that this person may need assistance in identifying and securing home- and community-based services.

(b) The county shall provide those individuals eligible for Medi-Cal and Medicare who may need support services in order to return home upon discharge with those services to the extent that the services are not provided by any other program. The county shall also provide those who may need support services after a stay in a skilled nursing facility or other licensed long-term care facility in order to return home with those services to the extent that the services are not provided by any other program.

(c) Services provided through case management may include maintenance or renovations to a home to accommodate an individual's disability or infirmity that brought on the hospitalization or stay in the skilled nursing facility and may include rental vouchers if an individual requires accommodation while renovations are completed or arrangements are made for permanent housing in the event the individual cannot return to their residence at the time of hospitalization but can live in a less restrictive environment than a skilled nursing facility or other licensed long-term facility.

22106. (a) Funds for case management, rental vouchers, and home renovation to enable a person to return to or remain in his or her residence shall be from both of the following sources:

(1) Federal funds for Medicare and Medicaid, including waivers.

(2) State savings realized from diverting individuals from placement in skilled nursing facilities and other institutions and transferring persons from those facilities to home or a less restrictive environment.

(b) The Department of Finance, with the assistance of the California Health and Human Services Agency and subject to review by the Legislative Analyst, shall establish a baseline of

expenditures for skilled nursing facility care based on the average of state and county expenditures for this care in the 2008–09, 2009–10, and 2010–11 fiscal years. This information may be used to determine the amounts that are saved each subsequent year from implementation of this division

(c) The expansion of case management services shall occur as savings in other programs allow.

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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