

AMENDED IN SENATE APRIL 20, 2010

AMENDED IN SENATE APRIL 5, 2010

SENATE BILL

No. 998

Introduced by Senators Liu and Alquist

February 9, 2010

An act to amend Section 1262.5 of, and to add ~~Section~~ *Sections 1262.9 and 1264.5* to, the Health and Safety Code, and to add Division 13 (commencing with Section 22100) to, and to repeal Section 22104 of, the Welfare and Institutions Code, relating to long-term care services.

LEGISLATIVE COUNSEL'S DIGEST

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

Existing law provides for the licensure of various health facilities, including general acute care hospitals, skilled nursing facilities, and intermediate care facilities, and congregate living health facilities by the State Department of Public Health. Certain of these facilities are included under the category of long-term health care facilities, as defined. A violation of these provisions is a crime. Existing law requires each hospital to have in effect a written discharge planning policy and process that requires appropriate arrangements for posthospital care and a process that requires that each patient be informed, orally or in writing, of the continuing care requirements following discharge from the hospital, as specified and additionally requires specific information to be provided to a patient anticipated to be in need of posthospital care.

This bill would require ~~the~~ *a hospital that is required to provide the, as part of its discharge policy, information given to a patients* anticipated to need posthospital care, *to provide the information* both orally and in writing to the patient and, if necessary, to his or her representative, at the earliest possible opportunity prior to discharge. By changing the

definition of an existing crime, this bill would impose a state-mandated local program.

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 or identify, by no later than July 1, 2012, a tool for the uniform long-term care services assessment of individuals in order to assist eligible 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.

This bill would, among other things, if the director makes a specified certification, require a county to establish a long-term care case management program for specified persons. The bill would require the program to provide prescribed services, including assessment of care needed for persons in long-term health care facilities, as defined, to enable them to reside in the community and the services necessary to provide that care, and would require the county or its designees to assign care managers to each long-term health care facility within the county. 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 may need specified assistance. *By changing the definition of an existing crime, this bill would impose a state-mandated local program.*

The bill also would require a long-term health care facility to display at least one poster, in an area accessible to residents, advertising the telephone number of the facility's designated case manager, thus changing the definition of an existing crime and imposing a state-mandated local program.

The bill would also require these persons, upon a discharge from a long-term health 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) California is home to the largest older adult population in
4 the nation. Currently, approximately 4.4 million older adults will
5 comprise almost 15 percent of the state's population. By 2030,
6 projections suggest that 8.3 million older adults will account for
7 nearly 18 percent of the population.
8 (b) California's services for older adults and other adults with
9 long-term care needs currently exist in an uncoordinated patchwork
10 of programs overseen by multiple state agencies and organizations,
11 rather than a coordinated continuum of care focused on providing
12 services that are consumer-centered, least restrictive, and most
13 cost effective.
14 (c) All older adults and other adults with long-term care needs
15 should have access to information about the services that are
16 available in order to avoid institutionalization and the services of
17 a counselor or case manager who can help navigate the multiple
18 health and social service programs that may provide benefits to
19 that individual.
20 (d) Given recent reports and recommendations, California needs
21 a strategic plan for long-term care services that will maximize the
22 use of finite resources and reduce the use of institutional care.
23 California's plan for the implementation of the federal Olmstead
24 decision is the beginning of the process of providing the statewide
25 service coordination and assessment necessary for a continuum of
26 services for those in need of long-term care, including older adults.
27 (e) The public interest would best be served by a broad array
28 of long-term care services that support persons who need these
29 services at home or in the community whenever practicable, and
30 that promote individual autonomy, dignity, and choice. In-home
31 supportive services and adult day health care are examples of

1 services that the state should prioritize with stable and adequate
2 funding.

3 (f) Other states, including Pennsylvania and Washington, have
4 invested in a coordinated approach for long-term care and home-
5 and community-based services that has improved the effectiveness
6 of the overall delivery system and reduced the rate of growth of
7 institutional care.

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

15 (h) Providing case management and transition services to
16 residents of institutions is in keeping with the federal Olmstead v.
17 L.C. (1999) 527 U.S. 581 decision and its focus on the rights of
18 persons with disabilities, including those who are aged, to have a
19 choice in where they live.

20 (i) Services provided through various Medicaid waivers and
21 through independent living centers, that assist persons to remain
22 in or return to their homes, can serve as a basis for providing case
23 management and transition services to additional individuals
24 eligible for these services.

25 (j) There is a need for a practical assessment of barriers to
26 returning home for aged persons and persons with disabilities who
27 reside in institutional care.

28 SEC. 2. Section 1262.5 of the Health and Safety Code is
29 amended to read:

30 1262.5. (a) Each hospital shall have a written discharge
31 planning policy and process.

32 (b) The policy required by subdivision (a) shall require that
33 appropriate arrangements for posthospital care, including, but not
34 limited to, care at home, in a skilled nursing or intermediate care
35 facility, or from a hospice, are made prior to discharge for those
36 patients who are likely to suffer adverse health consequences upon
37 discharge if there is no adequate discharge planning. If the hospital
38 determines that the patient and family members or interested
39 persons need to be counseled to prepare them for posthospital care,
40 the hospital shall provide for that counseling.

1 (c) The process required by subdivision (a) shall require that
2 the patient be informed, orally or in writing, of the continuing
3 health care requirements following discharge from the hospital.
4 The right to information regarding continuing health care
5 requirements following discharge shall apply to the person who
6 has legal responsibility to make decisions regarding medical care
7 on behalf of the patient, if the patient is unable to make those
8 decisions for himself or herself. In addition, a patient may request
9 that friends or family members be given this information, even if
10 the patient is able to make his or her own decisions regarding
11 medical care.

12 (d) (1) A transfer summary shall accompany the patient upon
13 transfer to a skilled nursing or intermediate care facility or to the
14 distinct part-skilled nursing or intermediate care service unit of
15 the hospital. The transfer summary shall include essential
16 information relative to the patient's diagnosis, hospital course,
17 pain treatment and management, medications, treatments, dietary
18 requirement, rehabilitation potential, known allergies, and treatment
19 plan, and shall be signed by the physician.

20 (2) A copy of the transfer summary shall be given to the patient
21 and the patient's legal representative, if any, prior to transfer to a
22 skilled nursing or intermediate care facility.

23 (e) A hospital shall establish and implement a written policy to
24 ensure that each patient receives, at the time of discharge,
25 information regarding each medication dispensed, pursuant to
26 Section 4074 of the Business and Professions Code.

27 (f) A hospital shall provide every patient anticipated to be in
28 need of long-term care at the time of discharge with contact
29 information for at least one public or nonprofit agency or
30 organization dedicated to providing information or referral services
31 relating to community-based long-term care options in the patient's
32 county of residence and appropriate to the needs and characteristics
33 of the patient. At a minimum, this information shall include contact
34 information for the area agency on aging serving the patient's
35 county of residence, local independent living centers, or other
36 information appropriate to the needs and characteristics of the
37 patient. This information shall be provided both orally and in
38 writing, and shall be provided to the patient, and, if applicable, the
39 patient's authorized representative, at the earliest possible
40 opportunity prior to discharge.

1 (g) A contract between a general acute care hospital and a health
2 care service plan that is issued, amended, renewed, or delivered
3 on or after January 1, 2002, may not contain a provision that
4 prohibits or restricts any health care facility's compliance with the
5 requirements of this section.

6 SEC. 3. Section 1262.9 is added to the Health and Safety Code,
7 to read:

8 1262.9. (a) A general acute care hospital may make a referral
9 to the designated case manager when it has a patient who will be
10 referred to a long-term health care facility and the hospital
11 anticipates that the placement will be needed for more than 21
12 days, or when it has a patient it believes can return home upon
13 discharge if certain services or modifications can be made that
14 the case manager can arrange and that without those services or
15 modifications a referral to a long-term health care facility will be
16 necessary.

17 (b) A licensed long-term health care facility shall inform the
18 designated case manager assigned to that facility when a new
19 patient or resident who is described in subdivision (b) of Section
20 22102 of the Welfare and Institutions Code is admitted and has
21 been or is expected to be a resident for 21 days or who has
22 expressed a preference for living at home or in the community and
23 may need assistance in identifying and securing home- and
24 community-based services. Referrals may be made before a patient
25 has been a resident for 21 days if it is likely that without assistance
26 from the case manager, the patient will not be able to return home
27 in fewer than 21 days from admission. Referrals shall be made on
28 or before the 21st day of a patient's residence.

29 (c) On and after January 1, 2013, a long-term health care
30 facility that admits a new patient or resident who is described in
31 subdivision (b) of Section 22102 of the Welfare and Institutions
32 Code and that has not made a referral pursuant to subdivision (b)
33 shall not receive Medi-Cal reimbursement until the referral has
34 been made, and shall not be reimbursed by Medi-Cal for those
35 days during which a referral should have been made but was not
36 made.

37 (d) For the purposes of this section, "long-term health care
38 facility" shall have the same meaning as defined in Section 22108
39 of the Welfare and Institutions Code.

1 (e) For the purposes of this section, “designated case manager”
2 means the case manager described in subdivision (g) of Section
3 22102 of the Welfare and Institutions Code.

4 (f) This section shall not be implemented unless the requirements
5 specified in subdivision (b) of Section 22106 of the Welfare and
6 Institutions Code are satisfied.

7 ~~SEC. 3.~~

8 SEC. 4. Section 1264.5 is added to the Health and Safety Code,
9 to read:

10 1264.5. Commencing January 1, 2012, a licensed long-term
11 health care facility, as defined in Section ~~22109~~ 22108 of the
12 Welfare and Institutions Code, shall display at least one poster, in
13 an area accessible to residents, advertising the telephone number
14 of the facility’s designated case manager. The poster shall be
15 developed in consultation with the designated case manager and
16 the State Department of Health Care Services.

17 ~~SEC. 4.~~

18 SEC. 5. Division 13 (commencing with Section 22100) is added
19 to the Welfare and Institutions Code, to read:

20
21 DIVISION 13. LONG-TERM CARE ASSESSMENT AND
22 PLANNING FOR INDIVIDUALS
23

24 22100. It is the intent of the Legislature to establish a long-term
25 care services system that does all of the following:

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

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

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

(3) A single point of entry that ensures that all individuals who receive long-term care services understand their options for remaining at home or in the community and that ensures that all long-term care service providers know where to direct individuals for an assessment of their options for home- and community-based services.

(4) The integration and expansion of Medi-Cal 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.

(7) Wraparound services, including case management, as described in Section 22102, for individuals whose income and situation are insufficient to enable them to navigate the obstacles to remain successfully at home or in the community, when these options are available and appropriate.

(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 their capability and interest, and involves them and their family members as partners in the development and implementation of long-term care services.

22101. (a) (1) The State Department of Health Care Services shall initiate a process, in collaboration with stakeholders, to develop or identify no later than July 1, 2012, a tool for the uniform, long-term care services assessment of individuals in order to assist eligible consumers, as described in subdivision (b) of Section 22102, 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 health care facilities, home health and hospice agencies, long-term care program representatives, including in-home supportive services and county representatives, and formal and informal direct caregivers. The uniform long-term care services assessment tool that shall be developed or identified shall assist eligible consumers in making informed choices about home and community options for individuals who are hospitalized and likely to need long-term care, individuals who reside in an institution, or individuals in the community who are likely to need long-term care.

(2) The department may develop or identify the uniform long-term care services assessment *tool* without meeting the rulemaking requirements of the Administrative Procedure Act, provided that at least one 30-day public comment period is used.

(3) In addition, the department shall, in collaboration with the stakeholders, establish training standards for case management and for the use of the uniform long-term care services assessment tool as part of the long-term care case management program described in Section 22102.

(b) In developing the uniform long-term care services assessment tool, the department and stakeholders in the development process shall consider for inclusion in the assessment tool 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 identification of barriers that prevent the individual from living at home, in the community, or in a less restrictive environment.

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

(8) The individual's need for referrals to programs and services.

(9) The individual's plan of care needs, which may include, but is not limited to, any of the following:

(A) Personal care and household assistance needs.

(B) Treatments or therapies, or both.

- 1 (C) Medication management.
- 2 (D) Seizures.
- 3 (E) Skin care.
- 4 (F) Preventive care.
- 5 (G) Risk of falls.
- 6 (H) Pain management.
- 7 (I) Cognitive capacity.
- 8 (J) Depression.
- 9 (K) Problem behaviors.
- 10 (L) Suicide risk.
- 11 (M) Substance abuse.
- 12 (N) Communication.
- 13 (O) Family supports and other nonfamilial support systems.
- 14 (P) Consumer goals.
- 15 (c) In developing or identifying the uniform; long-term care
- 16 services assessment *tool*, the department shall, in collaboration
- 17 with the stakeholders identified in subdivision (a), evaluate whether
- 18 existing federal, state, or county assessment tools or information
- 19 systems and processes may be used, integrated, or further
- 20 developed to meet the purposes of this section. Before the
- 21 department, in collaboration with the stakeholders, decides not to
- 22 develop its own uniform; long-term care services assessment *tool*
- 23 and, instead, decides to identify existing federal, state, or county
- 24 assessment tools or information systems and processes to use as
- 25 the uniform; long-term care services assessment *tool*, the
- 26 department and the stakeholders shall consider the extent to which
- 27 the existing federal, state, or county assessment tools or information
- 28 systems and processes consider the items listed in paragraphs (1)
- 29 to ~~(10)~~ (9), inclusive, of subdivision ~~(c)~~ (b), and the extent to which
- 30 the use of these tools, systems, or process is authorized or required
- 31 pursuant to federal law.
- 32 (d) The department shall, in collaboration with the stakeholder
- 33 groups identified in subdivision (a), develop recommended best
- 34 practices under which individuals who receive the uniform
- 35 long-term care services assessment and express a preference for
- 36 living at home or in another community-based setting, may also
- 37 receive all of the following:
- 38 (1) A comprehensive community services plan, to be developed
- 39 with the individual and, as appropriate, the individual's
- 40 representative.

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

6 (3) Information on retention of Supplemental Security
7 Income/State Supplementary Plan benefits, rental assistance
8 vouchers, home modification allowances, or home maintenance
9 allowances, and any other financial supports that would assist the
10 individual in maintaining his or her home during a hospital or
11 nursing facility stay.

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

14 22102. (a) It is the intent of the Legislature to establish a case
15 management program that identifies and secures services that will
16 enable an individual to return home from a hospital following an
17 illness or injury, to return home from a skilled nursing facility or
18 other long-term health care facility, and to remain at home or in
19 the community rather than residing in an institution.

20 ~~(b) With assistance from the State Department of Health Care~~
21 ~~Services, each county shall establish a long-term care case~~
22 ~~management program for persons who are Medi-Cal recipients or~~
23 ~~applicants or individuals eligible for both Medicare and Medi-Cal~~
24 ~~who are residing in a long-term health care facility, or who apply~~
25 ~~for admission to a long-term health care facility or are at imminent~~
26 ~~risk of being placed in a long-term health care facility.~~

27 *(b) With assistance from the State Department of Health Care*
28 *Services, each county shall establish a long-term care case*
29 *management program for individuals who are Medi-Cal recipients*
30 *or applicants, or who are eligible for both Medicare and Medi-Cal.*
31 *The individuals shall also meet at least one of the following*
32 *requirements:*

33 *(1) The individuals are residing in a long-term health care*
34 *facility.*

35 *(2) The individuals are applying for admission to a long-term*
36 *health care facility.*

37 *(3) The individuals are at imminent risk of being placed in a*
38 *long-term health care facility.*

39 (c) (1) In establishing the long-term care case management
40 program pursuant to subdivision (b), the county shall identify one

1 or more county departments or nonprofit organizations or a
2 combination of departments and nonprofit organizations to provide
3 case management. A county may contract with nonprofit
4 organizations for this purpose. These organizations may include,
5 but are not limited to, independent living centers, area agencies
6 on aging, providers of multipurpose senior services, linkages, aging
7 and disability resource connections programs, and public
8 authorities.

9 (2) The State Department of Health Care Services shall provide
10 guidance to counties to promote the provision of case management
11 services in ways that maximize federal financial participation. The
12 State Department of Health Care Services may contract directly
13 with nonprofit organizations, or a combination of departments and
14 nonprofit organizations, in lieu of a particular county or counties,
15 upon the request of a county or counties, to satisfy the requirements
16 of this section.

17 (d) The county shall identify eligible individuals described in
18 subdivision (b) who need support services in order to live at home
19 or in the community, and shall arrange for the provision of those
20 services to the extent that the services are not provided by any
21 other program, and to the extent that the provision of these services
22 would allow them to live safely at home or in the community. Of
23 these eligible individuals, the county shall give first priority to
24 individuals who have been or are expected to be residents of a
25 long-term health care facility for more than 21 days, but who can
26 reasonably be expected to return home or to the community if case
27 management services are provided. The next priority shall be given
28 to individuals who are referred by a general acute care hospital
29 who may be diverted from care at a licensed long-term health care
30 facility if case management services are provided and for
31 individuals who request and are eligible for case management
32 services in order to avoid being placed in a long-term health care
33 facility either from the community or home setting.

34 (e) Services provided through the case management program
35 shall include, but are not limited to, all of the following:

36 (1) Identifying, until the uniform, long-term care services
37 assessment *tool* is either developed or identified pursuant to Section
38 22101, any barriers to the individual's return to or remainder at
39 home or in the community. This identification of barriers shall be

1 replaced by the use of uniform, long-term care services assessment
2 when available.

3 (2) Enrolling, or assisting in the enrollment of, the individual
4 in home- and community-based programs, to the extent authorized
5 by the individual or individual's authorized representative, if
6 necessary for the individual.

7 (3) Developing and executing a care plan.

8 (4) Ensuring the coordination of health and social services that
9 meet the individual's needs.

10 (5) Coordinating maintenance of or renovations to a home to
11 accommodate an individual's disability or infirmity, if necessary
12 for the individual.

13 (6) Arranging for the payment of a home upkeep allowance for
14 utilities, including light, heat, water, and garbage pickup, if
15 necessary, for the individual.

16 (7) Applying for rental assistance vouchers or other retention
17 of income, to the extent authorized by the individual or individual's
18 authorized representative, if necessary for the individual. The case
19 manager may also provide rental assistance vouchers if an
20 individual requires accommodation while home renovations are
21 made or while arrangements are made for permanent housing if
22 the individual cannot return to his or her residence at the time of
23 discharge from a hospital, but can live in a less restrictive
24 environment than a skilled nursing facility or other licensed
25 long-term health care facility.

26 (8) Followup services to ensure that an individual's ongoing or
27 changing needs are being met.

28 (9) Community-reentry training or independent living training
29 for the individual, if necessary.

30 (f) If requested, a copy of the assessment provided for in
31 paragraph (1) of subdivision (e), shall be provided to the individual.

32 (g) The county or its designee shall assign case managers to
33 each long-term health care facility located within the county and
34 notify each of these long-term health care facilities of any changes
35 in personnel.

36 (h) Case managers and those doing the assessment shall not be
37 employees of a long-term health care facility or a general acute
38 care hospital, and shall meet the training standards established
39 pursuant to subdivision (a) of Section 22101.

1 (i) Any individual designated as a case manager shall have
2 access to any long-term health care facility in order to provide case
3 management services. Failure to provide this access may result in
4 the imposition of an administrative penalty against the long-term
5 health care facility.

6 ~~22103. (a) A general acute care hospital may make a referral
7 to the designated case manager when it has a patient who will be
8 referred to a long-term health care facility and the hospital
9 anticipates that the placement will be needed for more than 21
10 days, or when it has a patient it believes can return home upon
11 discharge if certain services or modifications can be made that the
12 case manager can arrange and that without those services or
13 modifications a referral to a long-term health care facility will be
14 necessary.~~

15 ~~(b) A licensed long-term health care facility shall inform the
16 designated case manager assigned to that facility when a new
17 patient or resident who is described in subdivision (b) of Section
18 22102 is admitted and has been or is expected to be a resident for
19 21 days or who has expressed a preference for living at home or
20 in the community and may need assistance in identifying and
21 securing home and community-based services. Referrals may be
22 made before a patient has been a resident for 21 days if it is likely
23 that without assistance from the case manager, the patient will not
24 be able to return home in fewer than 21 days from admission.
25 Referrals shall be made on or before the 21st day of a patient's
26 residence.~~

27 ~~(c) On and after January 1, 2013, a long-term health care facility
28 that admits a new patient or resident who is described in
29 subdivision (b) of Section 22102 and that has not made a referral
30 pursuant to subdivision (b) shall not receive reimbursement until
31 the referral has been made, and shall not be reimbursed for those
32 days during which a referral should have been made but was not
33 made.~~

34 ~~22104.~~

35 ~~22103. (a) By December 1, 2013, the State Department of
36 Health Care Services, in consultation with the Office of Statewide
37 Health Planning and Development, shall report to the Legislature
38 the total number of long-term care services assessments performed
39 in the state, along with all of the following:~~

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

3 (2) The total number of assessments of individuals in nursing
4 facilities.

5 (3) The total number of assessments of individuals in hospitals.

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

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

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

19 (b) (1) A report to be submitted pursuant to subdivision (a)
20 shall be submitted in compliance with Section 9795 of the
21 Government Code.

22 (2) Pursuant to Section 10231.5 of the Government Code, this
23 section shall remain in effect only until January 1, 2015, and as of
24 that date is repealed, unless a later enacted statute, that is enacted
25 before January 1, 2015, deletes or extends that date.

26 ~~22105.~~

27 ~~22104.~~ (a) The Department of Finance, with the assistance of
28 the California Health and Human Services Agency and subject to
29 review by the Legislative Analyst, shall establish a baseline of
30 expenditures for long-term health care facility care based on the
31 average of state and county expenditures for the services in the
32 2008–09, 2009–10, and 2010–11 fiscal years. This information
33 shall be used to determine the amounts that are saved each
34 subsequent year from implementation of this division.

35 (b) When the budget for home- and community-based services
36 is considered by the appropriate budget committees of the
37 Legislature, the Department of Finance, subject to review by the
38 Legislative Analyst, shall provide an estimate of the state savings
39 realized from placing individuals who would otherwise be placed

1 in or transferred to a licensed long-term health care facility in a
2 home or to a less restrictive environment.

3 ~~22106.~~

4 22105. The department shall pursue any additional necessary
5 waivers and state plan amendments to ensure federal financial
6 participation in funding increases to home- and community-based
7 services, including, but not limited to, in-home supportive services
8 and adult day health care, home maintenance and home
9 modification allowances, as well as training and employment of
10 individuals who will conduct the uniform long-term care
11 assessments and case management or counseling of individuals
12 eligible or at risk of needing long-term care.

13 ~~22107.~~

14 22106. (a) On or before July 1, 2011, the department shall, in
15 collaboration with stakeholders identified in subdivision (a) of
16 Section 22101, submit to the Legislature a financing plan for
17 providing long-term care services pursuant to this division.

18 (b) ~~Sections 22102, 22103, 22104, and 22105~~ *Section 1262.9*
19 *of the Health and Safety Code, and Sections 22102, 22103, and*
20 *22104* shall not be implemented unless the Director of Health Care
21 Services certifies that the collection of federal funds, other revenue
22 from restructuring of reimbursements, penalties, and fines, or
23 private funds, is sufficient to fund the implementation of long-term
24 care services assessments, case management or counseling, and
25 services pursuant to this division.

26 ~~22108.~~

27 22107. (a) As part of their responsibilities to develop the
28 process described in subdivision (d) of Section 22101, stakeholder
29 groups may review the treatment authorization requests process
30 described in ~~Sections 14133.01~~ *14133, 14133.01, and 14133.05*
31 and recommend to the State Department of Health Care Services
32 ways to improve the role of the treatment authorization requests
33 process in assisting those who wish to return home from a
34 long-term health care facility.

35 (b) By December 1, 2011, the department, in collaboration with
36 the stakeholders, shall submit to the Legislature recommended
37 changes, if any, to each of the following:

38 (1) The treatment authorization request process to promote the
39 more rapid movement of residents of long-term health care
40 facilities to home and community.

1 (2) The temporary or permanent restructuring of long-term care
2 reimbursement to provide reimbursement for a coordinated
3 program of home- and community-based services in lieu of
4 reimbursement for services provided in a skilled nursing facility,
5 when this program would allow an individual to remain in or return
6 to a community setting.

7 (3) Reimbursement for hospital, skilled nursing, and
8 rehabilitation care, so that this care will be provided at levels
9 sufficient to ensure beneficiary access to optimal medical and
10 functional recovery and to provide patient and caregiver education
11 directed toward successful transition to the community setting.

12 ~~22109.~~

13 *22108.* For purposes of this division, a long-term health care
14 facility includes a skilled nursing facility, intermediate care facility,
15 intermediate care facility/developmentally disabled, intermediate
16 care facility/developmentally disabled habilitative, intermediate
17 care facility/developmentally disabled nursing, and congregate
18 living health facility, as these terms are defined in Section 1250
19 of the Health and Safety Code.

20 ~~SEC. 5.~~

21 *SEC. 6.* No reimbursement is required by this act pursuant to
22 Section 6 of Article XIII B of the California Constitution for certain
23 costs that may be incurred by a local agency or school district
24 because, in that regard, this act creates a new crime or infraction,
25 eliminates a crime or infraction, or changes the penalty for a crime
26 or infraction, within the meaning of Section 17556 of the
27 Government Code, or changes the definition of a crime within the
28 meaning of Section 6 of Article XIII B of the California
29 Constitution.

30 However, if the Commission on State Mandates determines that
31 this act contains other costs mandated by the state, reimbursement
32 to local agencies and school districts for those costs shall be made
33 pursuant to Part 7 (commencing with Section 17500) of Division
34 4 of Title 2 of the Government Code.