AMENDED IN SENATE MARCH 25, 2011

AMENDED IN SENATE MARCH 9, 2011

SENATE BILL No. 21

Introduced by Senators Liu and Alquist

December 6, 2010

An act to amend Section 1262.5 of, and to add 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 22103 of, the Welfare and Institutions Code, relating to long-term care services.

LEGISLATIVE COUNSEL'S DIGEST

SB 21, 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 a hospital that is required to provide, as part of its discharge policy, information to 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, 2013, 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, among other things, would require a county to establish a long-term care case management program for specified persons if the director makes a specified certification. 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:

SECTION 1. The Legislature finds and declares all of the following:

(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 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, including Pennsylvania and Washington, have invested in a coordinated approach for long-term care and home- and community-based services that has 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 federal 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) On and after January 1, 2014, a long-term health care facility that admits a new patient or resident who is described in subdivision (b) of Section 22102 of the Welfare and Institutions Code and that has not made a referral pursuant to subdivision (b) ~~shall not receive Medi-Cal reimbursement until the referral has been made, and shall not be reimbursed by Medi-Cal for those days during which a referral should have been made but was not made.~~ *may be issued a citation pursuant to Section 1424. A citation shall not be issued for failure to refer a resident if the facility determined in good faith that services would not be needed for more than 21 days, but unanticipated delays result in the resident remaining in the facility for a limited period beyond 21 days.*

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

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

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

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

1264.5. Commencing January 1, 2013, a licensed long-term health care facility, as defined in Section 22108 of the Welfare and Institutions Code, shall display at least one poster, in an area accessible to residents, advertising the telephone number of the facility's designated case manager. The poster shall be developed in consultation with the designated case manager and the State Department of Health Care Services.

SEC. 5. 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) Multiple points of entry to a single system that ~~ensures~~ *ensure* that all individuals who receive long-term care services understand their options for remaining at home or in the community and that ~~ensures~~ *ensure* 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 financial 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, 2013, 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 *and the department responds to public comment*.

(3) In addition, the department, in collaboration with the stakeholders, shall 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 ensure that the assessment tool identifies individual and community barriers that prevent the individual from living at home, in the community, or in a less restrictive environment.

(c) In developing or identifying the uniform long-term care services assessment tool, the department, in collaboration with the stakeholders identified in subdivision (a), shall evaluate whether existing federal, state, or county assessment tools or information systems and processes may be used, integrated, or further developed to meet the purposes of this section. Before the department, in collaboration with the stakeholders, decides not to develop its own uniform long-term care services assessment tool and, instead, decides to identify existing federal, state, or county assessment tools or information systems and processes to use as the uniform long-term care services assessment tool, the department and the stakeholders shall consider the extent to which the use of these tools, systems, or processes is authorized or required pursuant to federal law.

(d) The department, in collaboration with the stakeholder groups identified in subdivision (a), shall develop recommended best practices under which individuals who receive the uniform long-term care services assessment, and express a preference for living at home or in another community-based setting, may 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 long-term health care facility care.

(3) Information on retention of Supplemental Security Income/State Supplementary Plan benefits, rental assistance vouchers, 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. (a) It is the intent of the Legislature to establish a case management program that identifies and secures services that will enable an individual to return home from a hospital following an illness or injury, to return home from a skilled nursing facility or other long-term health care facility, and to remain at home or in the community rather than residing in an institution.

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

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

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

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

(c) (1) In establishing the long-term care case management program pursuant to subdivision (b), the county shall identify one or more county departments or nonprofit organizations or a combination of departments and nonprofit organizations to provide case management. A county may contract with nonprofit organizations for this purpose. These organizations may include, but are not limited to, independent living centers, area agencies on aging, providers of multipurpose senior services, linkages, aging and disability resource connections programs, and public authorities.

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

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

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

(1) Identifying, until the uniform long-term care services assessment tool is either developed or identified pursuant to Section 22101, any barriers to the individual’s return to or remainder at

home or in the community. This identification of barriers shall be replaced by the use of uniform, long-term care services assessment when available.

(2) Identify any medical or therapeutic care that an individual needs in order to reenter the community, or a less restrictive environment.

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

(4) Developing and executing a care plan.

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

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

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

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

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

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

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

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

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

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

22103. (a) By December 1, 2014, the State Department of Health Care Services, in consultation with the Office of Statewide Health Planning and Development, 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 in nursing facilities.

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

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

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

(6) 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.

(b) The department also shall compare the data collected under subdivision (a) to the utilization data and length-of-stay data for residents of long-term care facilities in the prior year to measure the impact of case management on reducing the use of institutional care. The department shall analyze and report whether the number of residents utilizing more than 21 days in a long-term care facility, and the average length of stay of those residents beyond 21 days, have been reduced.

~~(b)~~

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

(2) Pursuant to Section 10231.5 of the Government Code, this section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

22104. (a) 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 long-term health care facility care based on the average of state and county expenditures for the services in the 2008–09, 2009–10, and 2010–11 fiscal years. This information shall be used to determine the amounts that are saved each subsequent year from implementation of this division.

(b) When the budget for home- and community-based services is considered by the appropriate budget committees of the Legislature, the Department of Finance, subject to review by the Legislative Analyst, shall provide an estimate of the state savings realized from placing individuals who would otherwise be placed in or transferred to a licensed long-term health care facility in a home or to a less restrictive environment.

22105. 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.

22106. (a) On or before July 1, 2012, the department, in collaboration with stakeholders identified in subdivision (a) of Section 22101, shall submit to the Legislature a financing plan for providing long-term care services pursuant to this division.

(b) Section 1262.9 of the Health and Safety Code, and Sections 22102, 22103, and 22104 shall not be implemented unless the Director of Health Care Services 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.

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

(b) By December 1, 2012, the department, in collaboration with the stakeholders, shall submit to the Legislature recommended changes, if any, to each of the following:

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

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

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

22108. For purposes of this division, a long-term health 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.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime

or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other 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.

O