AB-126 Health and human services. (2017-2018)

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Assembly Bill No. 126

CHAPTER 65

An act to amend Section 14132.99 of, and to add and repeal Section 4686.5 of, the Welfare and Institutions Code, relating to health and human services, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor July 10, 2017. Filed with Secretary of State July 10, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 126, Committee on Budget. Health and human services.

Existing law requires the State Department of Developmental Services, in consultation with stakeholders, to develop an alternative service delivery model that provides an Individual Choice Budget for obtaining quality services and supports that provides choice and flexibility within a finite budget that, in the aggregate, reduces regional center purchase of service expenditures, reduces reliance on the General Fund, and maximizes federal financial participation. Existing law places certain restrictions on the purchase of respite services, based on need and duration, until implementation of the Individual Choice Budget, as specified. AB 107 of the 2017–18 Regular Session would repeal the provision that places restrictions on the purchase of those services.

This bill would delay the repeal of that provision until January 1, 2018. The bill would appropriate $100,000 from the Federal Trust Fund to the department for purposes of implementation.

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, and under which qualified aged, blind, and disabled persons are provided with supportive services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law provides for various home- and community-based services waivers, such as the In-Home Operations Waiver and the Nursing Facility/Acute Hospital Transition and Diversion Waiver (NF/AH waiver), that promote coverage and services that enable an individual who would otherwise be institutionalized to live at home or in the community. Under the NF/AH waiver, a home- and community-based services waiver authorized under this federal law until March 31, 2016, home- and community-based services, such as case management and coordination, habilitation services, and community transition services, are provided to eligible Medi-Cal beneficiaries with long-term medical conditions who would otherwise receive care in a skilled nursing facility. AB 113 and SB 97 of the 2017–18 Regular Session would authorize the Director of Health Care Services, when renewing the NF/AH waiver, to seek additional increases in the scope of the home- and community-based NF/AH waiver and would make conforming changes.

This bill would make those conforming changes to the NF/AH waiver provisions.

Existing law prohibits a provider of in-home supportive services or waiver personal care services, or both, from working a total number of hours within a workweek that exceeds 66 hours, as specified. Existing law prohibits the provision of services by the provider to an individual recipient from exceeding the total weekly hours of the services authorized to that recipient, except as specified.

This bill, notwithstanding the 66-hour workweek limit and subject to receipt of any necessary federal approvals and federal financial participation, would require the State Department of Health Care Services to grant an exemption to a provider of an applicant or participant of the NF/AH waiver or the In-Home Operations Waiver, or their successors, whose medical or behavioral needs require that the services be provided by the requested provider, if one of specified circumstances exists. For a waiver participant who is enrolled in either waiver after January 31, 2016, the bill would require the department to grant a provider an exemption on a case-by-case basis, as specified. The bill would authorize a provider of in-home supportive services or waiver personal care services who is granted an exemption to work up to a total of 12 hours per day, and up to 360 hours per month, as specified. The bill would require the department to record the number of requests for exemptions, as specified.

This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.
Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4686.5 is added to the Welfare and Institutions Code, to read:

4686.5. (a) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, all of the following shall apply:

(1) A regional center may only purchase respite services when the care and supervision needs of a consumer exceed that of an individual of the same age without developmental disabilities.

(2) A regional center shall not purchase more than 21 days of out-of-home respite services in a fiscal year nor more than 90 hours of in-home respite services in a quarter, for a consumer.

(3) (A) A regional center may grant an exemption to the requirements set forth in paragraphs (1) and (2) if it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer.

(B) For purposes of this section, "family member" means an individual who:

(i) Has a consumer residing with him or her.

(ii) Is responsible for the 24-hour care and supervision of the consumer.

(iii) Is not a licensed or certified residential care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided. Notwithstanding this provision, a relative who receives foster care funds shall not be precluded from receiving respite.

(4) A regional center shall not purchase day care services to replace or supplant respite services. For purposes of this section, "day care" is defined as regularly provided care, protection, and supervision of a consumer living in the home of his or her parents, for periods of less than 24 hours per day, while the parents are engaged in employment outside of the home or educational activities leading to employment, or both.

(5) A regional center shall only consider in-home supportive services a generic resource when the approved in-home supportive services meets the respite need as identified in the consumer's individual program plan (IPP) or individualized family service plan (IFSP).

(b) For consumers receiving respite services on July 1, 2009, as part of their IPP or IFSP, subdivision (a) shall apply on August 1, 2009.

(c) This section shall remain in effect until implementation of the individual choice budget pursuant to Section 4648.6 and certification by the Director of the Department of Developmental Services that the individual choice budget has been implemented and will result in state budget savings sufficient to offset the costs associated with the repeal of this section. This section shall be repealed on the date of certification.

(d) This section shall remain in effect only until January 1, 2018, and as of that date is repealed.

SEC. 2. Section 14132.99 of the Welfare and Institutions Code is amended to read:

14132.99. (a) For the purposes of this section, “facility residents” means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term “facility residents” also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(d) (1) (A) Notwithstanding paragraphs (1) and (2) of subdivision (d) of Section 12300.4, the department shall grant an exemption, as described in paragraph (2), to a provider of an applicant or participant of the Nursing Facility/Acute Hospital Transition and Diversion Waiver or the In-Home Operations Waiver, or their successors, who was enrolled in either waiver on January 31, 2016, and whose medical or behavioral needs require that the services to the applicant or participant be provided by the requested provider, if any of the following circumstances exists:

(i) The provider lives in the same home as the waiver applicant or participant, even if the provider is not a family member.

(ii) The provider currently provides care to the waiver participant, and has done so for two or more years continuously.

(iii) The waiver applicant or participant is unable to find a local caregiver who speaks the same language as the applicant or participant, resulting in the applicant or participant being unable to direct his or her own care.

(B) For a waiver participant who enrolls in either waiver after January 31, 2016, the department shall grant a provider an exemption from the workweek requirements described in paragraphs (1) and (2) of subdivision (d) of Section 12300.4 on a case-by-case basis pursuant to paragraph (5).

(2) A provider of in-home supportive services or waiver personal care services who is granted an exemption pursuant to paragraph (1) may work up to a total of 12 hours per day, and up to 360 hours per month combined for the in-home supportive services and waiver personal care services that he or she provides, not to exceed each waiver participant’s monthly authorized hours.

(3) On a one-time basis upon implementation of this paragraph, the department shall mail an informational notice and an exemption request form to all providers who may be eligible for an exemption pursuant to this subdivision and to the waiver participants to whom the providers provide services.

(4) At the time of initial application, and at least annually, the department shall inform all waiver applicants or participants whose providers may be eligible for an exemption pursuant to this subdivision and their providers about the exemptions and the application process.

(5) (A) The department shall review the requests for consideration for an exemption described in subparagraph (B) of paragraph (1) pursuant to a process developed by the department with input from stakeholders. The department shall consider whether the waiver applicant or participant meets the criteria described in subparagraph (A) of paragraph (1) in making its determination.

(B) Within 30 days of receiving an application for an exemption described in subparagraph (B) of paragraph (1) from a provider and from a waiver applicant or participant on behalf of a provider, the department shall mail a written notification letter to the provider and the waiver applicant or participant for whom the provider provides services of its approval or denial of the exemption. If the department denies the exemption, the department shall also explain in the notification letter the

reason for the denial. The department shall use a standardized notification letter, developed by the department in consultation with stakeholders, for purposes of providing the notification letter that is required by this subparagraph.

(6) The department shall record the number of requests for exemptions that are received and the number of requests approved or denied. These numbers shall be posted no later than every three months on the department's Internet Web site.

(e) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services.

SEC. 3. The sum of one hundred thousand dollars ($100,000) is hereby appropriated from the Federal Trust Fund to the State Department of Developmental Services for the purposes of carrying out the provisions of this act related to community respite services. These funds shall be available for encumbrance or expenditure until June 30, 2018, and available for liquidation until June 30, 2020.

SEC. 4. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.