THE COUNCIL OF STATE GOVERNMENTS
SUGGESTED STATE LEGISLATION
SUPPLEMENT
A SILVER SOCIETY: AGING IN AMERICA

Docket 28AS
SUGGESTED STATE LEGISLATION SUPPLEMENT
A SILVER SOCIETY: AGING IN AMERICA
(Includes SSL drafts, recent state legislation, and legislation from recent SSL dockets)

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26 = Miscellaneous docket category; 28AS = Docket 28A (Supplement); 01 = Item number within category
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Managing Use of Health Care Treatments and Medications

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13-26A-03 Electronic Death Registration System (Rejected) NJ
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26-28AS-30 Unnecessary Institutionalization of People Age 60 and Older IL
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ABOUT THIS SUPPLEMENT

As baby boomers near retirement, and as health care costs continue to increase, the nation’s attention has turned increasingly to the much-discussed “age wave.” Policymakers and the media have highlighted the potential economic, social and political consequences of the fact that the 76 million Americans born between 1946 and 1964 will reshape our country’s policies as they grow older.

And, while many people associate aging with disease and disability, the reality is that Americans are living longer and healthier lives than ever before. And local, state and federal efforts to promote healthy aging can pay off in improved health, better quality-of-life and increased productivity for millions of seniors.

Vermont Governor James Douglas is the 2006 President of The Council of State Governments. His initiative as CSG’s president, “Spanning the Spectrum of Healthy Living - Childhood to Adulthood,” addresses the need for a comprehensive approach to healthy living. It explores many of the key ingredients to create and maintain healthy lifestyles and healthy communities. And it highlights how state policymakers can help their constituents and communities prepare for healthy, productive futures.

This Suggested State Legislation “Supplement” is part of Governor Douglas’ initiative. This supplement contains articles, Suggested State Legislation drafts, recent state legislation, and state legislation from previous SSL dockets, which address a variety of state services to America’s aging population.
OVERVIEW (Trends in America: Charting the Course Ahead – CSG, June 2005)

Two simple facts are shaping America’s future: People are living longer and having fewer children. The outcome of these two trends is that the percentage of older people in the United States is growing. The aging population will have profound consequences, which state leaders are beginning to recognize but largely have not addressed.

In the first half of the 20th century, the graphs of population distribution by age group resembled half-pyramids, with a large base of younger people supporting a small top layer of older people. Longer life expectancies in the future should change that half-pyramid into a bullet-shape.

Most social programs, public and private health insurance systems and retirement funds rely on younger working generations to support older generations. There are currently nearly five people of working age for each older person. In the near future, this ratio will drop to fewer than three workers for each older person. Demographers and policy-makers alike worry there will not be enough younger workers or productivity gains in the economy to adequately address these programs’ future financial needs.

According to the U.S. Census Bureau, the number of people older than 65 will more than double between 2000 and 2050, and the population over age 85 will quadruple. Fueling America’s population transformation are the 76 million baby boomers born between 1946 and 1964. This unusually large demographic group has changed America’s institutions as they have grown older, starting with schools and then moving into the work force. The boomers’ upcoming exodus from the work force will gain momentum rapidly as the first wave of boomers turns 65 in 2011.

What does this trend mean for states?

Americans’ expectations of what it means to get older are changing. This is partly because of the boomers’ influence. The boomers are healthier, more financially secure and more educated than previous generations. Despite these positive characteristics, the aging of the population will provide many challenges as well.

The aging of the population will continue to exert pressure on health care costs, forcing difficult choices.

According to the Centers for Disease Control and Prevention, health care expenditures for a 65-year-old on average are four times those for a 40-year-old. Because there will be more older people who live longer, experts predict that overall U.S. health care expenditures will increase 25 percent by 2030.

Long-term care needs are particularly problematic. The Medicaid program is currently the largest payer for those types of services, accounting for almost half of all long-term care spending. Few Americans have long-term care insurance or sufficient resources to provide for their needs should they become disabled. Thus, the government ends up picking up the tab.
Changing family structures combined with the aging population may lead to a caregiving crisis.

Currently, families provide most of the support for aging individuals. According to the National Family Caregiving Alliance, nearly one out of every four households is involved in caring for people age 50 or over. The combination of an aging populace and changing family structures—including fewer children, higher divorce rates, more single parent families, greater job mobility and delayed childbearing—means that family members may provide fewer of the support services seniors need in the future.

Because states and localities are often the human service payers and providers of last resort, there are concerns about the adequacy of social service networks and the potential rise of elder abuse and neglect. There is already a shortage of allied health professionals such as nurse aides, who could help fill the caregiving gap, and the shortage will only get worse in the next few years.

State tax structures may not be well-equipped to handle the aging of the population.

As the population ages, state tax collections will be affected. State budgets rely heavily on income and sales taxes for revenue. As more and more baby boomers retire, states may see a dramatic decline in income tax revenues. Why? For one thing, many states exempt all or part of private and public pension income from taxation. This results in a smaller tax base.

Although baby boomers are wealthier than previous generations, their consumption patterns may change as they age. For instance, older individuals may spend more money on non-taxed services such as health care. In addition, retired baby boomers may have less disposable income than they did while they were working, which could affect state sales tax revenues.

Also, many states have enacted a homestead exemption or have given tax credits that reduce the amount of property taxes paid by the elderly. This exemption may restrict local revenues, possibly putting greater emphasis on intergovernmental aid.

Work force shortages are on the horizon and will be particularly problematic in certain sectors of the economy.

Since a vibrant economy can translate into a healthy revenue base, states are closely examining aging’s impact on the work force. Baby boomers comprise as much as 60 percent of today’s prime-age work force, and their retirement will leave many vacancies.

Some economic sectors will be hit harder than others. Don Jakeway, CEO of the Michigan Economic Development Corporation, notes that the need for many manufacturing positions may be eliminated by industry advancements as technology, robotics and new techniques increase productivity and require fewer people.

However, the labor-intensive service sectors may face a different scenario. Health care, teaching and other service industries are expected to experience acute shortages as the need for additional workers increases just as many workers are eligible to retire. State governments are particularly vulnerable to future work force shortages. Thirty percent of the states work force will be eligible for retirement by 2006, according to a 2002 study by CSG and the National Association of State Personnel Executives.
State pension and retirement systems face funding problems.

As federal policy-makers debate the future of Social Security, state pension and retirement funds face similar funding dilemmas. The combination of poor economic returns in the recent past and growing liabilities from increasing numbers of retirees has translated into funding problems for nearly every state’s public retirement system.

This is occurring at a time when state revenues are not rising sharply and the costs of other state priorities, health care in particular, are increasing. Since state courts have declared that government must pay all pension benefits regardless of the state’s fiscal situation, states are looking into ways to deal with the current funding situation and avoid similar situations in the future.

There is a growing need for elder-ready communities.

“States and communities would be well advised to adapt their physical infrastructures and services to the needs of older Americans,” said Vermont Governor Jim Douglas. Elder-ready communities are pedestrian-friendly, have public transportation options and are relatively compact so that people do not have to travel far to get to the grocery store, pharmacy or health care providers. Because mobility is a major consideration as people age, elder-friendly communities focus on alleviating the problems associated with elderly drivers. As age increases, sensory and motor capabilities decline, perception and attention impairments become more common and, as a result, driving becomes more difficult. According to the National Highway Traffic Safety Administration, drivers over the age of 65 are more likely than all other drivers to be involved in and killed in traffic accidents on a per-mile-driven and per-licensed-driver basis.

Elder-ready communities have elder-friendly housing such as smaller, one-story dwellings. Older people often do not want to live in large houses that require a lot of upkeep. In addition, as more people retire and live on fixed incomes, housing affordability will become a major issue.

States are already promoting the concept of elder-ready communities. In 2000, Florida launched its Elder Ready Communities Program to help local leaders assess their community’s elder readiness and develop a plan to promote an elder-friendly environment. By actively encouraging local communities to be sensitive to the needs of seniors, states can play a major role in addressing the effects of the aging population.

What does the future hold?

In the next few years, we won’t experience cataclysmic effects from the aging population. The changes will be gradual, but over time the cumulative demographic, social and political consequences will likely be dramatic.

Scientific and medical advances will continue to contribute to long and relatively healthy lives. The recent trend toward policies that favor home- and community-based care, rather than institutional care, will continue, and new technologies will allow seniors to live independently longer. Health care and services that cater to older Americans will play an increasingly significant role in the economy. End-of-life and quality-of-life issues will take a prominent place in political debates as people live longer—sometimes with serious medical conditions.
The aging baby boomers will redefine what it means to retire. Many will continue working well into their 70s and 80s, perhaps retiring from one career to try something new. Others will be actively engaged in their communities through volunteer work or political activism. One way or another, the boomers will force policy-makers to reconsider the way retirement systems are structured and funded.

STATE SOLUTIONS (Trends in America, Navigating Turbulence to Success – CSG, December 2005)

Comprehensive State Programs

New York’s Project 2015 is a government-wide initiative to address the aging and increasing diversity of the state’s population. Begun in 1998, the effort is led by the state Office for the Aging. Thirty-six agencies have reviewed their policies, programs and structures in light of demographic changes and have identified top priorities that should be addressed within the next 10 years.

Similarly, Minnesota’s Project 2030 involved an intensive planning process in 1997 and 1998 to analyze the aging population’s impact on communities and state and local government.

In March 2005, Governor Jim Douglas signed an executive order creating a Commission on Healthy Aging. Composed of public and private experts from a variety of fields, the commission is working to ensure focus and coordination as Vermont strives to make healthy aging the rule, rather than the exception. The initiative has two goals: containing health care costs and keeping seniors healthy, active and productive in their communities.

State Efforts to Contain Health Care Costs

Two areas in which the age wave is already significantly affecting state governments are raising health care costs and the need to ensure adequate caregiving systems for seniors. States are using a variety of approaches to control the health care costs associated with caring for the elderly. To limit future Medicaid payments for long-term care services, some states have offered incentives for individuals to purchase long-term care insurance, while others are seeking ways for patients to use more of their personal assets to pay for nursing home care before becoming eligible for Medicaid. Other strategies include disease and injury prevention efforts, greater efficiencies in providing care, and restructuring state agencies that support seniors so they encourage independence and provide alternatives to nursing home care when appropriate.

Preventing Disease and Injury

Strategies to avert illness in the elderly are aimed at preventing or delaying chronic diseases and their complications, injuries and vaccine preventable infectious diseases. State efforts to promote healthy lifestyles and avoid chronic diseases focus on improving nutrition, reducing smoking and increasing physical activity. New York’s Supplemental Nutrition Assistance Program, for example, provides home-delivered meals, congregate meals, and nutritional counseling and education for the frail elderly at nutritional risk.

West Virginia’s Wheeling Walks program used a powerful eight-week media campaign to encourage seniors to walk, starting with 10-minute increments. Thirty percent of participants
surveyed after the program were regular walkers, compared with 16 percent in a comparison community. The program’s success was attributed to the intensity of the media campaign, supported by workplace events and physicians who wrote prescriptions for walking. Some educational efforts seek to reduce seniors’ susceptibility to traffic accidents.

The GrandDriver campaign is a social marketing campaign aimed at elderly drivers and their adult family members in Virginia, Maryland and the District of Columbia. Its goal is to make families aware of the signs of impaired driving and help the elderly make plans to stop driving. The initiative also encourages larger traffic lights, more prominent signs for intersections, more clearly marked street names, and automobile industry incentives to assess the impact of new technologies on older drivers.

Managing Use of Health Care Treatments and Medications

Another strategy to control health care costs is to integrate the appropriate use of medical technologies and treatments, in-home supports for patients and prescription medications. To reduce the cost of care for Medicaid patients with chronic conditions such as asthma, diabetes and hypertension, states have implemented disease management programs, which combine proven, cost-effective medical treatments with complete patient education. Georgia, for example, assigned case managers to frail and disabled Medicaid beneficiaries. The coordination of care decreased the need for nursing home and hospital care, and reduced overall per capita program costs. Other programs focus on educating patients with chronic diseases to manage their conditions and avoid complications. Washington state, for instance, started a telephone outreach service on self-management for Medicaid clients with asthma, diabetes, heart failure and chronic kidney disease. This led to estimated savings of $2 million by reducing emergency room visits and hospital admissions.

Appropriately prescribed and administered medications are often a cost-effective way to help individuals with chronic conditions stay healthy and control the complications of their diseases. Several states have addressed the affordability of prescription drugs. New York recently expanded the Elderly Pharmaceutical Insurance Coverage program by increasing income eligibility levels and reducing enrollment fees. Illinois, New Hampshire, Minnesota and Wisconsin are among the states that use the I-SaveRX program. Individuals use the state-sponsored system to directly purchase renewal prescriptions from pharmacies in Canada, England, Scotland and Ireland, where prices are 20 percent to 25 percent lower than in the United States. Arizona’s free CoppeRx Card provides seniors discounts at 500 pharmacies on some prescription drugs. And North Carolina integrated its Senior Care prescription assistance program with the new Medicare Prescription Drug discount cards, which enables seniors to take advantage of both programs at their pharmacies.

Integrating Support Programs for Efficiency

To enable older adults and their caregivers to seamlessly use lower cost community- and home-based services as an alternative to more costly nursing homes and assisted living, states have integrated the state agencies and programs that support these services. Oregon and Washington have completely integrated state aging and long-term care Medicaid services. In Wisconsin, an example of the approach many states have taken, state agencies have not been fully integrated, but the Family Care Program’s resource centers provide single entry points for
all types of long-term care services available to the elderly. These integrated systems allow consumers to choose less costly non-institutional sources for their care. Thus state resources are used in the most efficient manner. Services are coordinated through care management organizations that are paid for all services rendered to the elderly, including nursing home care, and are held accountable for patient results.

**State Approaches to Caregiving**

Closely associated with efforts to contain health care costs is the challenge of providing appropriate care for the elderly. State approaches range from efforts to support informal care provided by family and friends to initiatives centered on more formal systems of care. Although they take various forms, these initiatives generally share the recognition that helping seniors stay in their homes and communities as long as possible will save money and help them maintain their quality of life.

**Supporting Families and Communities**

One approach is to establish a physical and social environment that supports healthy aging in place and delays the need for caregiving as long as possible. Such an environment includes accessible, affordable housing linked with needed support services, transportation systems that keep older adults mobile once they stop driving, effective wellness and nutrition programs, and responsive mental health services. Florida’s Communities for a Lifetime is a statewide initiative to help communities create a better place for older adults to live, while benefiting all residents. Participating communities use their existing resources and technical assistance from the state to improve housing, health care, transportation, community education, and volunteer opportunities.

Other state programs help support individuals who care for aging family members. California’s Caregiver Resource Centers, for example, help families care for members with adult-onset brain impairments, including Alzheimer’s and stroke. Available services include information and referral, family consultation and care planning, respite care, counseling, support groups, education, and legal and financial consultation. Pennsylvania’s Family Caregiver Support program provides needs assessments, education, counseling, up to $200 a month to help pay for out-of-pocket expenses, and one-time grants of up to $2,000 for income-eligible families.

States are also allowing consumers and caregivers more control in selecting the service options that work best for them under state-supported programs. For example, the Illinois Local Area Agencies on Aging provide vouchers to family caregivers for goods and services they need to continue providing personal care to their family member. The average value of the vouchers is $1,000 per year, which can be used for items ranging from respite care and home modifications to haircuts and lawn care.

**Encouraging Home- and Community-Based Care**

In addition to supporting the informal care provided by family members and friends, states have also tested policy options related to formal systems of care, such as compensating family members who care for elderly relatives in their homes; enhancing benefits for home-
care workers by helping them obtain health insurance or increasing wages; and offering home-and community-based care models, including adult day care. For instance, New York, through its Community Services for the Elderly (CSE), provides a flexible, locally directed funding stream for community-based, supportive services for frail, low-income elderly who need assistance to maintain their independence at home. CSE supports adult day care, shopping assistance, counseling, transportation, protective or other services to maximize an elderly person’s independence in the home and community.

Several states have focused on comprehensive systems of home and community-based care. For example, Illinois’ Older Adult Services Act of 2004 promotes transforming the state’s comprehensive system of seniors’ services from a primarily facility-based system to a primarily home- and community-based system, taking into account the continuing need for 24-hour skilled nursing care and group housing with services. The restructuring will encompass the provision of housing, health, financial and supportive services. It will include all aspects of the delivery system regardless of the setting in which the service is provided.

In 2000, Connecticut launched its Home Care and Assisted Living Alternatives to Nursing Home Care Initiative, building on home- and community-based service options the state began in 1996. The program is designed to allow seniors in need of long-term supportive care to remain in the community and avoid or delay nursing home care. It also sponsors a variety of pilot projects where additional support is provided to enable the elderly to remain independent whether supported by state and HUD-funded independent living housing, private-payment for assisted living, or an expansion of income eligibility criteria for Connecticut’s home care program. Similarly, Florida’s Nursing Home Diversion Program, established through a Medicaid waiver, has been placing patients in less intensive levels of care since 1999. And New York provides non-medical in-home services, case management, non-institutional respite and ancillary services to functionally impaired elderly who are in need of community-based long-term care but who are not eligible for similar services under Medicaid.

FOOTNOTES

2State submission from New York via e-mail from Ed Ingoldsby, New York State Division of the Budget.
9See note 2 above.
18See note 12 above.
23See note 2 above.
LEGISLATION

Preventing Disease and Injury
26-28AS-01 Regarding the Revocation/Denial of an Elder’s Driver’s License Based on Statements Made by Their Treating Physicians (2007 SSL)

This Act directs that the state division of driver’s licensing may not issue or renew a driver’s license to any person when the division has received a written statement from a licensed treating physician or optometrist stating that the person is not capable of safely operating a motor vehicle. The licensed treating physician or optometrist may request an examination by the division. The division can also require an individual to submit to a reexamination when the division staff believe an individual is unsafe or otherwise unqualified to be licensed. Upon the conclusion of the examination or the refusal to be examined the division may cancel the driver’s license.

Submitted as:
Wyoming
HB 0059/Enrolled Act No. 41
Status: Enacted into law in 2005.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act to Establish Procedures to Revoke Driver Licenses.”

Section 2. [Authority of State Driver License Division to Cancel License or Permit.] The [division] may cancel any driver's license or instruction permit upon determining that the licensee or permittee was not entitled to the license or permit, that the licensee or permittee failed to give the required or correct information in his application, or that the license or permit has been altered or upon receipt of a written statement from a licensed treating physician or optometrist stating that the licensee or permittee is not capable of safely operating a motor vehicle. The licensed treating physician or optometrist may request an examination by the [division] under [insert citation].

Section 3. [Severability.] [Insert severability clause.]

Section 4. [Repealer.] [Insert repealer clause.]

Section 5. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-02 Emergency Evacuation Plans for People with Disabilities (2004 SSL)

This Act directs that by January 1, 2004, every high-rise building owner must establish and maintain an emergency evacuation plan for disabled occupants of the building who have notified the owner of their need for assistance. As used in the Act, "high-rise building" means any building 80 feet or more in height. The owner is responsible for maintaining and updating the plan as necessary to ensure that the plan continues to comply with the provisions of the Act. It exempts municipalities with more than 1,000,000 people and which already have ordinances establishing emergency procedures for high-rise buildings.

Submitted as:
Illinois
Public Act 92-0705
Status: Enacted into law in 2002.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act to Establish Emergency Evacuation Plans in High-Rise Buildings for People with Disabilities.”

Section 2. [Scope.] This Act does not apply within a municipality with a population of over [1,000,000] that, before the effective date of this Act, has adopted an ordinance establishing emergency procedures for high-rise buildings.

Section 3. [Required Emergency Evacuation Plan for People with Disabilities.] By January 1, 2004, every high-rise building owner must establish and maintain an emergency evacuation plan for disabled occupants of the building who have notified the owner of their need for assistance. As used in this Act, "high-rise building" means any building [80] feet or more in height. The owner is responsible for maintaining and updating the plan as necessary to ensure that the plan continues to comply with the provisions of this Act.

Section 4. [Plan Requirements.]
(a) Each plan must establish procedures for evacuating people with disabilities from the building in the event of an emergency, when those people have notified the owner of their need for assistance.

(b) Each plan must provide for a list to be maintained of people who have notified the owner that they are disabled and would require special assistance in the event of an emergency. The list must include the unit, office, or room number location that the disabled person occupies in the building. It is the intent of this Act that these lists must be maintained for the sole purpose of emergency evacuation. The lists may not be used or disseminated for any other purpose.

(c) The plan must provide for a means to notify occupants of the building that a list identifying people with a disability in need of emergency evacuation assistance is maintained by the owner, and the method by which occupants can place their name on the list.
Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act authorizes counties to establish an interagency elder death review team to help local agencies identify and review suspicious elder deaths and to facilitate communications among people who perform autopsies and people involved in the investigation or reporting of elder abuse or neglect. It specifies that county elder death review teams shall be comprised of certain public and private entities and the procedures for the sharing or disclosure of information by elder death review teams.

Submitted as:
California
Chapter 301 of 2001

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as the “Elder Death Review Teams Act.”

Section 2. [Legislative Findings.] The Legislature finds and declares the following:
(a) Interagency child death teams have been used successfully to ensure that the incidents of child abuse or neglect are recognized and other siblings and non-offending family members receive the appropriate services in cases where a child has died.
(b) Interagency domestic violence review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for prevention and intervention initiatives to reduce the incidence of domestic violence.
(c) There is a need to ensure that incidents of elder abuse or neglect are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for prevention and intervention initiatives to reduce the incidence of elder abuse and neglect.

Section 3. [Definitions.] As used in this Act, unless the context requires otherwise:
(a) “Elder” means any person who is sixty-five (65) years old or older.
(b) (1) “Abuse” means any of the conduct described in [insert citation].
(2) Abuse does not include the use of any reasonable and necessary force that may result in an injury used by a peace officer acting within the course of his or her employment as a peace officer.

Section 4. [Elder Death Review Teams Established.]
(a) Each county may establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communication among people who perform autopsies and the various people and agencies involved in elder abuse or neglect cases.
(b) Each county may develop a protocol that may be used as a guideline by people performing autopsies on elder adults to assist coroners and other people who perform autopsies
in the identification of elder abuse, in the determination of whether elder abuse or neglect contributed to death or whether elder abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for elder abuse or neglect, including the designation of the cause and mode of death.

Section 5. [Composition of Elder Death Review Teams.] County elder death review teams may be comprised of, but not limited to, the following:

(a) Experts in the field of forensic pathology.
(b) Medical personnel with expertise in elder abuse and neglect.
(c) Coroners and medical examiners.
(d) District attorneys and city attorneys.
(e) County or local staff including, but not limited to:
   (1) Adult protective services staff.
   (2) Public administrator, guardian, and conservator staff.
   (3) County health department staff who deal with elder health issues.
   (4) County counsel.
(f) County and state law enforcement personnel.
(g) Local long-term care ombudsman.
(h) Community care licensing staff and investigators.
(i) Geriatric mental health experts.
(j) Criminologists.
(k) Representatives of local agencies that are involved with oversight of adult protective services and reporting elder abuse or neglect.
(l) Local professional associations of people described in subdivisions (a) to (k), inclusive.

Section 6. [Documentation Confidentiality.]

(a) An oral or written communication or a document shared within or produced by an elder death review team related to an elder death review is confidential and not subject to disclosure or discoverable by another third party.
(b) An oral or written communication or a document provided by a third party to an elder death review team, or between a third party and an elder death review team, is confidential and not subject to disclosure or discoverable by a third party.
(c) Notwithstanding subdivisions (a) and (b), recommendations of an elder death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the elder death review team.

Section 7. [Information Sharing.]

(a) Each organization represented on an elder death review team may share with other members of the team information in its possession concerning the decedent who is the subject of the review or any person who was in contact with the decedent and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. The intent of this subdivision is to permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other provision of law.
(b) (1) Written and oral information may be disclosed to an elder death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (3) may rely on the request in determining whether information may be disclosed to the team.

(2) No individual or agency that has information governed by this subdivision shall be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(3) The following information may be disclosed pursuant to this subdivision:

   (A) Notwithstanding [insert citation], medical information.

   (B) Notwithstanding [insert citation], mental health information.

   (C) Notwithstanding [insert citation], information from elder abuse reports and investigations, except the identity of people who have made reports, which shall not be disclosed.

   (D) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in [insert citation].

   (E) Notwithstanding [insert citation], information pertaining to reports by health practitioners of people suffering from physical injuries inflicted by means of a firearm or of people suffering physical injury where the injury is a result of assaultive or abusive conduct.

   (F) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to [insert citation], as well as the information on which these reports are based.

   (G) Notwithstanding [insert citation], records relating to in-home supportive services, unless disclosure is prohibited by federal law.

(c) Written and oral information may be disclosed under this section notwithstanding [insert citation], the lawyer-client privilege protected by [insert citation], the physician-patient privilege protected by [insert citation], and the psychotherapist-patient privilege protected by [insert citation].

(d) Information gathered by the elder death review team and any recommendations made by the team shall be used by the county to develop education, prevention, and if necessary, prosecution strategies that will lead to improved coordination of services for families and the elder population.

Section 8. [Severability.] [Insert severability clause.]

Section 9. [Repealer.] [Insert repealer clause.]

Section 10. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS

( ) Include in 2008 Supplement

( ) Reject

Comments/Note to staff:
This Act requires employees and residents of long-term care facilities to be immunized against influenza and pneumococcal disease.

Submitted as:
New York
SB 5462-B
Status: Passed Senate and Assembly as of September, 1999.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act to Require Long-Term Care Facility Residents and Employees to be Immunized.”

Section 2. [Definitions.] For purposes of this Act:
1. “Long-term care facility” or “facility” means a residential health care facility as defined in [insert citation], adult home as defined in [insert citation] or enriched housing program as defined in [insert citation], adult day health program in accordance with [insert citation], and any other facility providing residential housing for [five (5)] or more people over the age of [sixty-five (65)] unrelated to the operator and supportive services including, but not limited to, food service, laundry, arranging for medical care, and assistance with daily living.

2. “Documentation” means written evidence from an individual’s health care provider indicating the date and place when the individual received the influenza vaccine or the pneumococcal vaccine.

3. “Medically contraindicated” means influenza or pneumococcal vaccine should not be administered to an individual because it may be detrimental to the individual’s health if the individual receives the vaccine.

4. “Employee” means an individual employed (whether directly, by contract with another entity or as an independent contractor) by a long-term care facility, on a part-time or full-time basis.

Section 3. [Long-Term Care Resident and Employee Immunization Required.] Every long-term care facility in this state shall require residents and employees to be immunized for influenza virus and pneumococcal disease in accordance with regulations of the [commissioner].

Section 4. [Resident Immunization.]  
1. Upon admission, a long-term care facility shall notify the resident of the immunization requirements of this Act and request that the resident agree to be immunized against influenza virus and pneumococcal disease.

2. Every long-term care facility shall document the annual immunization against influenza virus and immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking such immunization or the long-term care facility or individual is unable to provide documentation that the individual has received the appropriate immunization, the
long-term care facility shall provide or arrange for immunization. Immunization and the documentation thereof shall take place no later than [insert date].

3. An individual who becomes a resident after [insert date] but before [date] shall have his or her status for influenza and pneumococcal immunization determined by the facility, and if found to be deficient, the facility shall provide or arrange for the necessary immunization.

Section 5. [Employee Immunization.]
1. Every long-term care facility shall notify every employee of the immunization requirements of this Act and request that the employee agree to be immunized against influenza virus and pneumococcal disease.
2. The long-term care facility shall require documentation of annual immunization against influenza virus and immunization against pneumococcal disease for each employee. Upon finding that an employee is lacking such immunization or the long-term care facility or individual is unable to provide documentation that the individual has received the appropriate immunization, the long-term care facility must provide or arrange for immunization. Immunization and the documentation thereof shall take place no later than [insert date] of each year.
3. An individual who is newly employed as an employee after [insert date] but before [date] shall have his or her status for influenza and pneumococcal immunization determined by the facility, and if found to be deficient, the facility shall provide or arrange for the necessary immunization.

Section 6. [Exceptions.] No individual shall be required to receive either an influenza vaccine or pneumococcal vaccine if the vaccine is medically contraindicated, or if it is against his or her religious beliefs, or if he or she refuses the vaccine after being fully informed of the health risks of such action.

Section 7. [Rules and Regulations; Report.]
1. The [commissioner] shall promulgate regulations relating to the immunization requirements of this Act, taking into consideration the recommendations of the Centers for Disease Control and Prevention.
2. The [commissioner] is hereby directed to make available educational and informational materials to all long-term care facilities with respect to vaccination against influenza virus and pneumococcal disease.
3. The [commissioner] shall report [three (3)] years from the effective date of this Act to the [governor], the [president of the Senate], the [speaker of the Assembly], the [minority leader of the Senate] and the [minority leader of the Assembly] on the number of outbreaks in long-term care facilities each year due to influenza virus and pneumococcal disease and number of hospitalizations of long-term care facility residents each year due to influenza virus, pneumococcal disease and complications thereof.

Section 8. [Severability.] [Insert severability clause.]

Section 9. [Repealer.] [Insert repealer clause.]

Section 10. [Effective Date.] [Insert effective date.]
Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act makes all officers and employees of banks, federal and state credit unions and their affiliates who suspect financial elder or dependent adult abuse, as specified, mandated reporters of suspected financial abuse of elders and dependent adults. This bill makes a failure by a mandated reporter to report suspected financial abuse of an elder or dependent adult subject to civil penalties currently imposed on other mandated reporters of elder or dependent adult abuse, and makes such penalties payable by the employer financial institution.

Submitted as:
California
Chapter 140 of 2005
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act establishes a long-term care loan fund and directs the state bureau of workers' compensation to operate a long-term care loan fund program. The purpose of the program is to make loans without interest to employers that are nursing homes for the purpose of allowing those employers to purchase, improve, install, or erect sit-to-stand floor lifts, ceiling lifts, other lifts, and fast electric beds, and to pay for the education and training of personnel, in order to implement a facility policy of no manual lifting by employees of residents by employees.

Submitted as:
Ohio
Excerpted from HB 66
Status: Enacted into law in 2005.

Comment: The text of this draft is excerpted from a broad bill that addresses many state agencies.

Submitted by American Nurses Association - State legislation to prevent disabling musculoskeletal injuries and promote patient safety

Nursing practice and musculoskeletal disorders (MSDs)

Patient handling tasks are recognized as the primary cause for musculoskeletal disorders among the nursing workforce. Of primary concern are back injuries and shoulder strains which can both be severely debilitating.

A variety of patient handling tasks exist within the context of nursing care, such as lifting, transferring, and repositioning patients, and, are typically performed manually.

The physical environment of the health care setting also contributes to work-related musculoskeletal disorders. Configurations of and area within patient rooms and the placement of furniture and treatment equipment (i.e. critical care unit monitors, ventilator machines) can limit the space needed for patient handling situations.

Proper body mechanics is a “myth.” Traditionally taught to student nurses to counteract the physical stress of patient handling, such as lifting, so-called “proper” body mechanics do not translate well into nursing practice. Early findings of body mechanics studies were based on static loads (i.e. boxes with handles) and primarily focused on men.

A profession at risk

Compared to other occupations, nursing personnel are among the highest at risk for MSDs. The Bureau of Labor Statistics (2000) lists RNs sixth in a list of at-risk occupations for strains and sprains that included nursing personnel, with nurses’ aides, orderlies and attendants (first); truck drivers (second); labors (third); stock handlers and baggers (seventh); and construction workers (eighth).

Additional estimates for the year 2000 show the incidence rate for back injuries involving lost work days was 181.6 per 10,000 full-time workers in nursing homes and 90.1 per 10,000
full-time workers in hospitals, whereas incidence rates were 98.4 for truck drivers, 70.0 for construction workers, 56.3 for miners and 47.1 for agriculture workers.

Lower back injuries are also the most costly MSD affecting workers. Studies of back-related workers compensation claims reveal that nursing personnel have the highest claim rates of any occupation or industry.

Research on the impact of musculoskeletal injuries among nurses:
- 52 percent complain of chronic back pain;\(^1\)
- 12 percent of nurses are “leaving for good” because of back pain as the main contributory factor;\(^2\)
- 38 percent suffered occupational-related back pain severe enough to require leave from work\(^3\)

Effectiveness of safe patient handling equipment & devices

The development of assistive patient handling equipment and devices has essentially rendered the act of strict “manual” patient handling unnecessary as a function of nursing care. Assistive patient handling equipment and devices control the ergonomic hazard associated with patient handling by technologically “engineering out” the energy/force imposed onto the health care workers during the act of lifting, transferring or repositioning patients.

A growing number of health care facilities have incorporated patient handling technology and have reported positive results. Injuries among nursing staffs have dramatically declined since implementing patient handling equipment and devices along with an institutional commitment to the safest available methods. As a result, the number of lost days secondary to injury and staff turnover has declined. Cost-benefit analyses have also shown that assistive patient handling technology successfully reduces workers’ compensation costs related to musculoskeletal disorders.

Patient benefits

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The potential for patient injury, such as falls and skin tears, as a consequence of a manual handling mishap is reduced by using assistive equipment and devices. They provide a more secure process of lifting, transferring, or repositioning tasks.

Using assistive patient handling equipment contributes to patient comfort. Patients experience less awkward or forceful handling as compared to lifting, transferring or repositioning that is done manually.

Patient dignity is protected by using assistive equipment and devices.

Resources

The American Nurses Association’s Handle with Care Campaign Web site
www.nursingworld.org/handlewithcare/

Patient Safety Center of Inquiry, Tampa Veteran’s Health Administration
www.patientsafetycenter.com

Occupational Safety and Health Administration’s voluntary ergonomics guidelines for the prevention of musculoskeletal disorders in nursing homes

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
Texas legislative staff report that Texas suffers from a shortage of nurses in both hospitals and nursing homes. This shortage could be partially addressed by instituting practices that will make the profession safer for nurses and patients.

This Act encourages safe patient handling in the nursing work environment and by doing so creates a better, safer practice environment for nurses and their patients. Such an environment will help attract and retain nurses and also help nurses extend their careers in direct patient care. The Act applies to hospitals and nursing homes because that is where most high-risk patient handling occurs.

This Act defines "hospital" and "nursing home" and requires the governing body of a hospital or the quality assurance committee of a nursing home to adopt and ensure implementation of a policy to identify, assess, and develop strategies to control risk of injury to patients and nurses associated with lifting, transferring, repositioning, or movement of a patient.

The law provides minimum requirements to include: an analysis of the risk of injury to both patients and nurses posed by the patient handling needs of the patient populations served by the hospital or nursing home and the physical environment in which patient handling and movement occurs, education of nurses in the identification, assessment, and control of risks of injury to patients and nurses during patient handling, evaluation of alternative ways to reduce risks associated with patient handling, including evaluation of equipment and the environment, restriction of manual patient handling or movement of all or most of a patient's weight to emergency, life-threatening, or otherwise exceptional circumstances, collaboration with and annual report to the nurse staffing committee, procedures for nurses to refuse to perform or be involved in patient handling or movement that involves unacceptable risk of injury, submission of an annual report to the governing body or the quality assurance committee, and consideration of the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment into architectural plans for construction or remodeling at a hospital or nursing home in which patient handling and movement occurs, which may be used at a later date.

Submitted as:
Texas
SB 1525 (enrolled version)
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
(  ) Include in 2008 Supplement
(  ) Reject

Comments/Note to staff:
LEGISLATION

Managing Use of Health Care Treatments and Medications
This Illinois Act provides for a new program of pharmaceutical assistance to the aged and disabled, which shall be administered by the state Department of Healthcare and Family Services and the Department on Aging. The Act provides that to become a beneficiary under the new program, a person must (1) be either age 65 or older or disabled, (2) be domiciled in the state, (3) enroll with a qualified Medicare Part D Prescription Drug Plan if eligible, and (4) have a maximum household income of less than specified amounts depending on household size.

This law provides that people enrolled as of December 31, 2005, in the pharmaceutical assistance program under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act and anyone enrolled as of December 31, 2005, in the SeniorCare Medicaid waiver program operated by the state shall be automatically enrolled in the new program. It divides the new program beneficiaries into 4 “eligibility groups.” It provides that the program shall cover the cost of covered prescription drugs in excess of the beneficiary co-payments ($2 for each prescription of a generic drug and $5 for each prescription of a brand-name drug) that are not covered by Medicare.

The law provides a new definition of "covered prescription drug" for purposes of the new program. Any person otherwise eligible for pharmaceutical assistance under the new program whose covered drugs are covered by any other public program is ineligible for assistance under the new program to the extent that the cost of those drugs is covered by the other program. This Act sets forth conditions of participation in the new program for pharmacies.

The Act amends the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act. The law provides that the prescription drug discount program is for residents instead of only senior citizens and disabled people. It provides for administration of the Act by the Department of Healthcare and Family Services (successor agency to the Department of Public Aid) instead of the Department of Central Management Services.

This law changes the requirements that a proposal for administering the program must meet, including requirements that a proposal specify the amount of the discount based on the average wholesale price of the covered medications and administrative fees charged by the administering entity. The law eliminates provisions setting forth limits on the amounts paid for medications by people enrolled in the program and specifying the formula for calculating the amounts paid by the program administrator to pharmacies.

This Act provides for a program enrollment fee to be determined by the Director of Healthcare and Family Services (instead of $25), and makes changes concerning collection of the enrollment fee. It provides that to be eligible to participate in the program, a person must be a resident of the state and must have household income equal to or less than 300% of the Federal Poverty Level.

The law eliminates a provision that any person who is eligible for pharmaceutical assistance under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is presumed to be eligible for this program.

Submitted as:
Illinois
Public Act 094-0086
Status: Enacted into law in 2005.
Disposition:

SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff:
This Act:
- Authorizes the Secretary of State, subject to the availability of funding, to establish and maintain an online health care directives registry;
- Requires the registry to be accessible through a web site maintained by the Secretary of State;
- Establishes that failure to register a health care directive with the Secretary of State does not affect the validity of a health care directive;
- Stipulates filing requirements for the registry may include the following notarized or witnessed documents and any notarized or witnessed revocations of these documents:
  A. A health care power of attorney;
  B. A living will; or
  C. A mental health care power of attorney.
- Stipulates that the Secretary of State is not required to review documents submitted to ensure compliance with state law;
- Requires people who submit a document for registration to provide a return address and submit any fee prescribed by the Secretary of State for the registry;
- Establishes that failure to notify the Secretary of the revocation of a document does not affect the validity of a health care directive;
- Establishes a process by which health care directives submitted are reviewed for accuracy by the people submitting them;
- Stipulates that entries may only be activated upon confirmation of accuracy;
- Requires the Secretary of State to assign registrants a unique file number and password upon receipt of a completed registration form;
- Requires the Secretary of State to provide registrants with a card that identifies their file number and password;
- Establishes that online health care directives are only accessible by entering the file number and password on the Internet web site;
- Declares health care directives are confidential and shall not be disclosed to anyone other than the person who submitted the document or the person’s personal representative;
- Requires the Secretary of State to delete a document filed when the Secretary receives revocation of a document along with that document’s file number and password;
- Prohibits the Secretary from using information contained in submitted documents for any other purpose;
- Requires the Secretary of State to purge documents from the registry every five years in order to eliminate documents of people who have passed away;
- Instructs the director of state department of health services to share registry of death certificates with the Secretary of State for purging purposes;
- Prohibits the legislature from appropriating or transferring general fund monies or other state monies to support, promote and maintain the registry;
- Establishes a Health Care Directives Registry Fund consisting of monies received by the Secretary for operation of the registry;
• Allows the Secretary of State to accept gifts, grants, donations, bequests and contributions to support, maintain and promote the registry;
  • Requires the Secretary to use fund monies to support, promote and maintain the registry;
  • Directs that the Secretary shall administer the fund, and the monies in the fund are continuously appropriated;
  • Requires the State Treasurer, upon notice of the Secretary of State, to invest and divest monies in the fund; monies earned from investment shall be credited to the fund;
  • Stipulates that health care providers are not required to request information from the registry about whether the patient has executed a health care directive;
  • Stipulates that this Act does not affect the duty of the health care providers to provide information to a patient regarding health care directives;
  • Clarifies that health care providers may access the registry for the purpose of providing care if the provider has the patient’s password and file number;
  • Stipulates that a health care provider who relies in good faith on a health care directive filed with the registry is immune from liability;
  • Allows the Secretary, upon request of the person who submitted a document, to transmit health care directive information to the registry system of another jurisdiction; and
  • Exempts the state from civil liability (except for acts of gross negligence, willful misconduct or intentional wrongdoing) for any claims or demands arising out of the administration and operation of the registry.

Submitted as:
Arizona
Chapter 219 of 2004
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act to Establish a Registry of Health Care Directives.”

Section 2. [Establishing a Health Care Directives Registry.]

A. Subject to the availability of monies, the [secretary of state] shall establish and maintain a Health Care Directives Registry.

B. The registry shall be accessible through a web site maintained by the [secretary of state].

C. The [secretary of state] may accept gifts, grants, donations, bequests and other forms of voluntary contributions to support, promote and maintain the registry. The [legislature or the secretary of state] shall not appropriate or transfer state general fund or other state monies to support, promote and maintain the registry.

Section 3. [Filing Requirements.]

A. A person may submit to the [secretary of state], in a form prescribed by the [secretary of state], the following documents and any revocations of these documents for registration:

1. a health care power of attorney.
2. a living will.
3. a mental health care power of attorney.

B. The person who submits a document for registration pursuant to this section must provide a return address.

C. Documents submitted pursuant to this section must be notarized or witnessed as prescribed by this Act.

Section 4. [Effect of Non-registration or Revocation.]

A. Failure to register a document with the [secretary of state] pursuant to this Act does not affect the validity of a health care directive.

B. Failure to notify the [secretary of state] of the revocation of a document filed pursuant to this Act does not affect the validity of a revocation that otherwise meets the requirements for a revocation pursuant to this Act.

Section 5. [Registration; Purge of Registered Documents.]

A. On receipt of a completed registration form, the [secretary of state] shall create a digital reproduction of the form, enter the reproduced form into the health care directives registry database and assign each registration a unique file number and password.

B. The [secretary of state] is not required to review a document to ensure that it complies with the particular statutory requirements applicable to the document.

C. After entering the reproduced document into the registry database, the [secretary of state] shall return the original document to the person who submitted the document and provide that person with a printed record of the information entered into the database under the file number and a wallet size card that contains the document’s file number and a password.

D. The person who submitted the document shall review the printed record. If the information is accurate, the person shall check the box marked “no corrections required” and sign and return the printed record to the [secretary of state].

E. If the person who submitted the document determines that the printed record is inaccurate, the person shall correct the information and sign and return the corrected printed record to the [secretary of state]. On receipt of a corrected printed record, the [secretary of state] shall make the proper corrections and send a corrected printed record to the person who submitted the document. If the information is accurate, the person shall check the box marked “no corrections required” and sign and return the corrected printed record to the [secretary of state’s office].

F. The [secretary of state] shall activate the entry into the Health Care Directives Registry Database only after receiving a printed record marked “no corrections required.”

G. The [secretary of state] shall delete a document filed with the registry pursuant to this section when the [secretary of state] receives a revocation of a document along with that document’s file number and password.

H. The entry of a document pursuant to this Act does not:

1. affect the validity of the document.
2. relate to the accuracy of information contained in the document.
3. create a presumption regarding the validity of the document or the accuracy of information contained in the document.

I. The [secretary of state] shall purge a document filed with the registry on verification by the [director of the department of health services] of the death of the person who submitted 63
the document. The [secretary of state] shall purge the registry of documents pursuant to this subsection at least once every [five years]. The [director of the department of health services] shall share its registry of death certificates with the [secretary of state] in order to conduct the document purge required by this subsection.

Section 6. [Registry Information; Confidentiality; Transfer of Information.]
A. The registry established pursuant to this Act is accessible only by entering the file number and password on the Internet web site.
B. Registrations, file numbers, passwords and any other information maintained by the [secretary of state] pursuant to this Act are confidential and shall not be disclosed to any person other than the person who submitted the document or the person’s personal representative.
C. Notwithstanding subsection B, a health care provider may access the registry and receive a patient’s health care directive documents for the provision of health care services by submitting the patient’s file number and password.
D. The [secretary of state] shall use information contained in the registry only for purposes prescribed in this Act.
E. At the request of a person who submitted the document, the [secretary of state] may transmit the information received regarding the health care directive to the registry system of another jurisdiction as identified by the person.

Section 7. [Liability; Limitation.]
A. Except for acts of gross negligence, willful misconduct or intentional wrongdoing, this state is not subject to civil liability for any claims or demands arising out of the administration or operation of the registry established pursuant to this Act.
B. This Act does not require a health care provider to request from the registry information about whether a patient has executed a health care directive. A health care provider who makes good faith health care decisions in reliance on the provisions of an apparently genuine health care directive received from the registry is immune from criminal and civil liability to the same extent and under the same conditions as prescribed in [insert citation].
C. This Act does not affect the duty of a health care provider to provide information to a patient regarding health care directives pursuant to federal law.

Section 8. [Health Care Directives Registry Fund.]
A. The [Health Care Directives Registry Fund] is established consisting of monies received pursuant to this Act. The [secretary of state] shall administer the fund. Monies in the fund are continuously appropriated.
B. On notice from the [secretary of state], the [state treasurer] shall invest and divest monies in the fund as provided by [insert citation], and monies earned from investment shall be credited to the fund.
C. The [secretary of state] shall use fund monies to support, promote and maintain the registry.
D. Fund monies shall not include monies appropriated from the state [General Fund].

Section 9. [Severability.] [Insert severability clause.]
Section 10. [Repealer.] [Insert repealer clause.]
Section 11. [Effective Date.] [Insert effective date.]
Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-08 Prescription Drug Labels: Purpose of Drug (2004 SSL)

This Act specifies that prescription labels must include information concerning the purpose for which a drug is being prescribed if a patient requests that information. It also specifies that a pharmacist may fill a prescription even if the information is not provided, without having to contact the practitioner or patient. Physicians, podiatrists, dentists, optometrists, advance practice nurses and physician assistants would be required to inform patients of the option to have this information included on the prescription label, but failure to do so would not result in any disciplinary action against the practitioner’s professional license.

Submitted as:
Colorado
Chapter 78 of 2003
Status: Enacted into law in 2003.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Requiring Certain Information on Prescription Drug Labels.”

Section 2. [Definition.] As used in this Act, “Order” means a prescription order which is any order, other than a chart order, authorizing the dispensing of a single drug or device that is written, mechanically produced, computer generated and signed by the practitioner, transmitted electronically or by facsimile, or produced by other means of communication by a practitioner and that includes the name or identification of the patient, the date, the symptom or purpose for which the drug is being prescribed, if included by the practitioner at the patient’s authorization, and sufficient information for compounding, dispensing, and labeling.

Section 3. [Prescription Drug Labeling.]
(A) A prescription drug dispensed pursuant to an order as defined in this Act must be labeled as follows:
(1) If the prescription is for an anabolic steroid, the purpose for which the anabolic steroid is being prescribed shall appear on the label.
(2) If the prescription is for any drug other than an anabolic steroid, the symptom or purpose for which the drug is being prescribed shall appear on the label, if, after being advised by the practitioner, the patient or the patient’s authorized representative so requests.
(B) If the symptom or purpose for which a drug is being prescribed is not provided by the practitioner, the pharmacist may fill the prescription order without contacting the practitioner, patient, or the patient’s representative, unless the prescription is for an anabolic steroid.

Section 4. [Prescriptions - Requirement to Advise Patients.]
(A) Physicians or Physician Assistants:
(1) A physician licensed under [insert citation], or a physician assistant licensed under [insert citation] and who has been delegated the authority to prescribe medication, may
advise the physician’s or the physician assistant’s patients of their option to have the symptom or purpose for which a prescription is being issued included on a prescription order.

(2) A physician’s or a physician assistant’s failure to advise a patient under subsection (A)(1) of this section shall not be grounds for any disciplinary action against the physician’s or the physician assistant’s professional license.

(3) Failure to advise a patient pursuant to subsection (1) of this section shall not be grounds for any civil action against a physician or physician’s assistant in a negligence or tort action, nor shall such failure be evidence in any civil action against a physician or a physician’s assistant.

(B) Podiatrists:

(1) A podiatrist licensed under [insert citation] may advise the podiatrist’s patients of their option to have the symptom or purpose for which a prescription is being issued included on the prescription order.

(2) A podiatrist’s failure to advise a patient under subsection (B)(1) of this section shall not be grounds for any disciplinary action against the podiatrist’s professional license.

(3) Failure to advise a patient pursuant to subsection (B)(1) of this section shall not be grounds for any civil action against a podiatrist in a negligence or tort action, nor shall such failure be evidence in any civil action against a podiatrist.

(C) Dentists:

(1) A dentist licensed under [insert citation] has the right to prescribe such drugs or medicine, perform such surgical operations, administer such general or local anesthetics, and use such appliances as may be necessary to the proper practice of dentistry. A dentist shall not prescribe, distribute, or give to a family member or himself or herself any habit-forming drug, as defined in [insert citation], or any controlled substance, as defined in [insert citation], other than in the course of legitimate dental practice and pursuant to the rules promulgated by the [state board of dentistry] regarding controlled substance record keeping.

(2) A dentist licensed under [insert citation] may advise the dentist’s patients of their option to have the symptom or purpose for which a prescription is being issued included on the prescription order.

(3) A dentist’s failure to advise a patient under subsection (C)(2) of this section shall not be grounds for any disciplinary action against the dentist’s professional license.

(4) Failure to advise a patient pursuant to subsection (C)(2) of this section shall not be grounds for any civil action against a dentist in a negligence or tort action, nor shall such failure be evidence in any civil action against a dentist.

(D) Advanced Practice Nurses:

(1) An advanced practice nurse who has been granted authority to prescribe prescription drugs and controlled substances under [insert citation] may advise the nurse's patients of their option to have the symptom or purpose for which a prescription is being issued included on the prescription order.

(2) A nurse’s failure to advise a patient under subsection (D)(1) of this section shall not be grounds for any disciplinary action against the nurse’s professional license.

(3) Failure to advise a patient pursuant to subparagraph (D)(1) of this section shall not be grounds for any civil action against a nurse in a negligence or tort action, nor shall such failure be evidence in any civil action against a nurse.

(E) Optometrists:
(1) An optometrist licensed under [insert citation] may advise the optometrist's patients of their option to have the symptom or purpose for which a prescription is being issued included on the prescription order.

(2) An optometrist’s failure to advise a patient under subsection (E)(1) of this section shall not be grounds for any disciplinary action against the optometrist's professional license.

Section 5. [Severability.] [Insert severability clause.]

Section 6. [Repealer.] [Insert repealer clause.]

Section 7. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act directs the state board of health, the state board of pharmacy and the state health commission to jointly develop and implement a pilot program through which unused prescription drugs, other than opiates, can be transferred from nursing facilities to pharmacies operated by city-county health departments or county pharmacies for the purpose of distributing the medication to state residents who are medically indigent. Medically indigent people are those who have no health insurance or who lack reasonable means to purchase prescribed medications.

The Act also:
- Authorizes residents of a nursing facility, or the representative or guardian of a resident, to donate unused non-opiate prescription medications for dispensation to medically indigent people;
- Makes an exception to provisions of the pharmacist licensure laws that prohibit pharmacists from selling, bartering, or giving away unused medications for participation in the program;
- Provides liability protection for physicians, pharmacists, and other health care professionals for participation in the program when acting within the scope of practice of their license and in good faith compliance with the rules promulgated pursuant to the Act;
- Requires that the rules promulgated to implement the program provide for:
  1. A formulary for the medications to be distributed pursuant to the program,
  2. The protection of the privacy of the individual for whom the medication was originally prescribed,
  3. The integrity and safe storage and safe transfer of the medication, which may include limiting the drugs made available through the program to those that were originally dispensed by unit dose or an individually sealed dose or which remain in intact packaging, and
  4. The tracking of and accountability for the medications; and
- Requires the state board of health, the state board of pharmacy, the state health commission, the state board of medical licensure and supervision, and the state board of osteopathic examiners to review and evaluate the program no later than 18 months after its implementation and report any recommendations to the governor and the Legislature.

Submitted as:
Oklahoma
HB1297 (enrolled version)

**Suggested State Legislation**

(Title, enacting clause, etc.)

1. Section 1. [Short Title.] This Act may be cited as the “Utilization of Unused Prescription Medications Act.”
2. Section 2. [Pilot Program.]
   (A) The [State Board of Health], the [State Board of Pharmacy] and the [State Health Care Authority] shall jointly develop and implement a pilot program consistent with public health and safety through which unused prescription drugs, other than prescription drugs defined
as controlled dangerous substances by [insert citation], may be transferred from nursing facilities to pharmacies operated by city-county health departments or county pharmacies for the purpose of distributing the medication to residents of this state who are medically indigent.

(B) The [State Board of Health], the [State Board of Pharmacy], the [State Health Care Authority], the [State Board of Medical Licensure and Supervision], and the [State Board of Osteopathic Examiners] shall review and evaluate the program no later than [eighteen (18)] months after its implementation and shall submit a report and any recommendations to the [Governor], the [Speaker of the House of Representatives], the [President Pro Tempore of the Senate], and the [Chairs] of the appropriate legislative committees.

(C) The [State Board of Health], the [State Board of Pharmacy] and the [State Health Care Authority] shall promulgate rules and establish procedures necessary to implement the program established by this section. The rules and procedures shall provide:

1. For a formulary for the medications to be distributed pursuant to the program;
2. For the protection of the privacy of the individual for whom the medication was originally prescribed;
3. For the integrity and safe storage and safe transfer of the medication, which may include but shall not be limited to limiting the drugs made available through the program to those that were originally dispensed by unit dose or an individually sealed dose or which remain in intact packaging;
4. For the tracking of and accountability for the medications; and
5. For other matters necessary for the implementation of the program.

(D) In accordance with the rules and procedures of a program established pursuant to this section, the resident of a nursing facility, or the representative or guardian of a resident may donate unused prescription medications, other than prescription drugs defined as controlled dangerous substances by [insert citation], for dispensation to medically indigent people.

(E) Physicians, pharmacists and other health care professionals shall not be subject to liability for participation in the program established by this Act when acting within the scope of practice of their license and in good faith compliance with the rules promulgated pursuant to the Utilization of Unused Prescription Medications Act.

(F) For purposes of this section, “medically indigent” means a person who has no health insurance or who otherwise lacks reasonable means to purchase prescribed medications.

Section 3. [Penalties.] It shall be unlawful for any person, firm or corporation to sell, offer for sale, barter or give away any unused quantity of drugs obtained by prescription, except through a program pursuant to the Utilization of Unused Prescription Medications Act or as otherwise provided by the State Board of Pharmacy or except as permitted by [insert citation].

Section 4. [Severability.] [Insert severability clause.]

Section 5. [Repealer.] [Insert repealer clause.]

Section 6. [Effective Date.] [Insert effective date.]

Disposition:
SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject
Comments/Note to staff:
Outpatient prescription drugs, which are not covered by Medicare, represent a substantial out-of-pocket expense for many elderly people. This is cited as a shortcoming of the Medicare program, the federal health insurance program for older and disabled Americans.

At least twenty-one states are reported to have considered legislation to help senior citizens afford prescription drugs. This note highlights California, Delaware, Florida, Nevada, New Jersey, New York and Pennsylvania.

California

In California, state law provided for the Medi-Cal program, administered by the state department of health services, under which qualified low-income people are provided with health care services, including prescription benefits. Under existing law, the department paid participating pharmacists a discounted price for drugs on the Medi-Cal drug formulary. Existing law separately regulated the operation of pharmacies.

California Chapter 946 of 1999 authorizes payment of a price not to exceed the Medi-Cal reimbursement rate for prescription medicines, and an amount to cover electronic-transmission charges by Medicare beneficiaries, upon showing their Medicare card and prescription, as a condition of a pharmacy’s participation in the Medi-Cal program.

The law also requires the state department of health services to conduct a study of the adequacy of Medi-Cal pharmacy reimbursement rates, including the cost of providing prescription drugs and services.

Delaware

Delaware Substitute for Senate Bill 6, enacted into law in 1999, provides payment assistance for prescription drugs to Delaware’s low-income senior and disabled citizens who are ineligible for, or do not have, prescription drug benefits or coverage through federal, state or private sources.

To be eligible, a person must be a U.S. citizen or lawfully admitted alien, 65 years old or older or disabled by criteria established by Title II of the Social Security Act, be a resident of Delaware; be ineligible for Medicaid and the Nemours Pharmaceutical Assistance Program; have no other prescription drug benefits or coverage; and have an annual income of less than 200 percent of the federal poverty level. (The federal poverty level is computed each year. As of 3/8/99 it was $8,240 annual income for one person and $11,060 annual income for a husband and wife.)

At present, Medicaid and the Nemours Health Clinic Pharmaceutical Assistance Program assist Delaware’s senior citizens with drug prescriptions’ costs where annual income is less than $12,500 if single and less than $17,125 if married. This program introduces a third tier of assistance by subsidizing prescription drug costs for senior citizens whose annual income is between $12,500 and $16,480, and for married senior citizens whose combined income is between $17,125 and $22,120, and for disabled citizens with income between $8,240 and $16,480 for a single and $11,060 and $22,120 for a couple.
Payment assistance is limited to $2,500 per eligible person per fiscal year and co-payment amounts will be required. A pharmacist may not dispense drugs under this program until the co-payment has been made.

Services covered are generic and brand name FDA-approved and other legal prescription drugs, as well as cost-effective over-the-counter drugs prescribed by a physician. Necessary diabetic supplies not covered by Medicare also will be covered.

The Department of Health and Social Services will administer the program and will promulgate and adopt rules and regulations consistent with this Act.

Florida

Florida Chapter 2000-254 creates a catastrophic pharmaceutical expense assistance program for people over 65 who have an income at or below 250 percent of the federal poverty level and who have out-of-pocket prescription expenses that exceed or are projected to exceed 10 percent of their incomes. The program is not an entitlement and is to be administered by the agency for health care administration (AHCA) in consultation with the department of elderly affairs (DOEA). The law requires that, to the extent possible, administration of the program (including eligibility determination, claim processing, and reporting) use existing administrative mechanisms such as the Medicaid fiscal agent and area agencies on aging.

The Act requires AHCA to make payments for prescription drugs on behalf of eligible people, and AHCA and DOEA must develop a single-page application for the catastrophic pharmaceutical expense program. In addition, AHCA is required to establish eligibility requirements, limits on participation, benefit limitations, a requirement for generic-drug substitution and other program parameters comparable to Medicaid for the program. AHCA must also report annually to the Legislature on the operation of the program.

Florida’s law requires that, as a condition of participation in the Medicaid program and the catastrophic pharmaceutical expense program, a pharmacy must agree that the charge to any Medicare beneficiary who presents a Medicare card be no greater than the Medicaid rate for ingredients and dispensing fees, plus 2.5 percent of the Medicaid ingredient payment.

The Act finds that physicians and other health care professionals have a fiduciary responsibility to act in the best interests of their patients and requires the board of medicine, the board of osteopathic medicine, the board of podiatric medicine and the board of dentistry to adopt guidelines to discourage health care practitioners under their jurisdictions from accepting gifts, payments, subsidies or other financial inducements from pharmaceutical manufacturers which may undermine the practitioners’ independent judgment. Complimentary samples of drugs are not included as gifts, payments, subsidies or financial inducements. The law mandates that each of these boards require the practitioners under their jurisdiction to disclose gifts, subsidies payments and other financial inducements from manufacturers which conflict with the practitioners’ duty of loyalty to his or her patients.

Florida’s law provides an appropriation to the agency for health care administration to provide Medicaid services for people whose incomes are between 90 and 100 percent of the federal poverty level, to implement the catastrophic pharmaceutical expense assistance program, and to develop a computerized system to allow participating pharmacies to determine the maximum allowable charge for prescription drugs sold to Medicare beneficiaries.

Nevada
Nevada Chapter 538 of 1999 creates a fund for a healthy Nevada, which will be used in part to provide for subsidies to senior citizens for pharmaceutical services. Money for the fund will come from the proceeds of the state’s tobacco-settlement agreement.

New Jersey

New Jersey established a Pharmaceutical Assistance to the Aged & Disabled (PAAD) program in 1975 (currently cited as New Jersey CH. 30:4D-20). People are eligible for New Jersey’s PAAD program if:
- they are a New Jersey resident;
- their income is less than $18,587 if they are single, or less than $22,791 if they are married; and
- they are at least 65 years of age, or at least 18 years of age and receiving Social Security disability benefits.

New Jersey’s PAAD program helps eligible New Jersey residents pay for prescription drugs, insulin, insulin needles, certain diabetic testing materials and syringes and needles for injectable medicines used for the treatment of multiple sclerosis. Only drugs approved by the Food and Drug Administration are covered.

Drugs purchased outside New Jersey are not covered, nor is any pharmaceutical product whose manufacturer has not agreed to provide rebates to the state of New Jersey.

With a PAAD card, beneficiaries pay the pharmacist only $5 for each covered prescription. People who have health insurance or retirement benefits that provide prescription coverage equal to or better than PAAD, or are receiving Medicaid, are not eligible. However, they are eligible if their health insurance or retirement plan offers limited or partial coverage.

New Jersey has established a list of generic drugs which must be dispensed whenever a brand name drug has been prescribed. Prescribing physicians must write “Brand Medically Necessary” on the prescription to require the dispensing of some brand-name drugs when a generic is available. Generic drugs are less costly substitutes with the same active ingredients as drugs sold under a brand name. If a doctor prescribes the brand name and permits substitution, but a patient prefers a specific brand-name medication, PAAD participants may pay the difference between the listed generic drug and brand name, plus the $5 payment. Effective November 1, 1998, new legislation requires the initial prescription to be limited to a 34-day supply and subsequent refills to be dispensed at up to a 34-day supply or 100 doses whichever is greater. This adjustment will prevent the waste of medication, if the initial prescription is not appropriate for the beneficiary, and will allow those people who are on maintenance drugs to receive up to 100 unit doses for subsequent refills.

New Jersey also established an enhanced Drug Utilization Review (DUR) component for the PAAD program to safeguard against harmful drug/drug interactions, doses that are too small to too large, overextended drug therapy or drug duplication.

New York

New York’s Elderly Pharmaceutical Insurance Coverage (EPIC) Program is a New York state-sponsored prescription plan for senior citizens who need help paying for their prescriptions. Almost 100,000 seniors already belong and are saving over half the cost of their medicines.
New York state residents can join EPIC if they are 65 or older, and have an annual income of $18,500 or less if single, or $24,400 or less if married. Seniors who receive Medicaid benefits or have other prescription coverage that is better than EPIC are not eligible for EPIC benefits.

Beginning January 1, 2001, the income eligibility limits will increase. Single seniors with annual incomes up to $35,000 and married seniors with combined annual incomes up to $50,000 will be eligible. The new program includes a lower cost fee plan for those with incomes up to $20,000 (single) or $26,000 (married) and a deductible plan for seniors with incomes between $20,000 and $35,000 (single) or between $26,000 and $50,000 (married). In addition, the co-payments will be reduced so that seniors can save even more at the pharmacy.

EPIC is a cost-sharing program. Depending on their annual income, seniors may join EPIC by enrolling in the Fee Plan or the Deductible Plan. Seniors with low and moderate incomes are eligible for the Fee Plan; the cost to join this plan is based on annual income. Seniors may pay their annual fee in quarterly installments. There is no fee to join the Deductible Plan which is only available to seniors with moderate incomes.

Those enrolled pay full price for their prescriptions until they meet an annual deductible which also is based on income. There is no need to send in receipts; EPIC keeps track of how much deductible enrollees have spent.

After the deductible is met, these enrollees save more than half of their prescription costs for the rest of the year. At the drugstore, those enrolled in the Fee Plan and those enrolled in the Deductible Plan who have met their annual deductible show their EPIC cards, and make a payment between $3 and $23 for each prescription, depending upon the total cost of the prescription.

Almost all prescription medicines are covered, as well as insulin, and insulin syringes and needles. Both brand name and less expensive generic drugs are included. Enrollees can buy up to 100 tablets, or a 30-day supply at a time.

New York reportedly established its program in 1987.

Pennsylvania

Pennsylvania’s Pharmaceutical Assistance Contract for the Elderly (PACE) program and PACENET (network) help income eligible Pennsylvania residents over the age of 65 with the cost of their prescription medications.

PACE assists elderly people with lower annual incomes. PACE pays for all but a portion of the cost of each medication prescribed by a doctor. Enrolled PACE cardholders are responsible for paying a co-payment at the time they get their prescription from their pharmacist. Co-payment is $6 per prescription medication.

Cardholders must be residents of Pennsylvania at least 90 days prior to application. Gross income for the previous year must be less than $14,000 for single people and less than $17,200 for married applicants. Income from all sources, both taxable and non-taxable, must be reported.

PACENET assists eligible, elderly people with higher annual incomes. Enrolled PACENET cardholders must first satisfy an annual $500 deductible before PACENET begins paying for their medications. The deductible represents the cardholder’s first $500, annually (based on eligibility year), in out-of-pocket expenses for prescription medications. The PACENET cardholder must also pay a co-payment for each prescription received after the
deductible is satisfied. Once $500 is reached, the cardholder is responsible only for a co-payment for every prescription he or she receives. PACENET co-payments are $8 for generic drugs and $15 for brands.

Cardholders must be a resident of Pennsylvania at least 90 days prior to application. Gross income for the previous year must be less than $16,000 for single people and less than $19,200 for married applicants.

PACE and PACENET cover most medications which require a prescription in Pennsylvania, as well as insulin, insulin syringes and insulin needles.

All prescriptions dispensed by a pharmacist and paid for by PACE are subject to PACE Mandatory Substitution Regulations. PACE/PACENET require the pharmacist to substitute a generic prescription medication when the U.S. Food and Drug Administration indicates a generic exists and is rated “A” in equivalence to the brand-name medication that a PACE cardholder was prescribed by their doctor. The cardholder can choose not to accept the generic, but will be liable to pay the co-payment and 70 percent of the average wholesale cost of the brand-name drug their doctor prescribed. The co-payment of $8 or $15 must also be paid in these circumstances.

PACE/PACENET will pay the remaining 30 percent.

Exceptions to the mandatory generic substitution requirement may be granted but must be requested from PACE by a doctor.

Pennsylvania reportedly established PACE in 1984 (currently cited as 72 PS § 3761-501 to 709). PACENET was added by Public Law 741, No. 134 of 1996.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
21-26A-01A Dissemination of Medicare Pharmaceutical Benefits Information; Certain Training of Senior Citizen Volunteers (Rejected) VA

This Act requires the state Commissioners of Health and the Department for the Aging to disseminate, with such funds as may be made available, information to the public relating to recent congressional actions relating to pharmaceutical benefits to be provided under the Medicare program and how such benefits may help senior citizens with the costs of pharmaceutical benefits. This bill also requires the Commissioner of Health and the Commissioner of the Department for the Aging to develop a strategy, in coordination with the Virginia Area Agencies on Aging, for disseminating information to the public concerning the availability of pharmaceutical assistance programs and for training senior citizen volunteers to assist in completing applications for pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

Submitted as:
Virginia
Chapter 73, 2004
Status: Enacted into law in 2004.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act allows certain people to execute a psychiatric advance directive. It sets forth requirements for a psychiatric advance directive and provides immunity for a person who violates a psychiatric advance directive for certain reasons. This bill specifies that a physician is not precluded from treating the patient in a manner that is in the best interest of the patient or another individual. It provides that a health care representative may act in accordance with a psychiatric advance directive.

Submitted as:
Indiana
SEA 133 (enrolled version)
Status: Enacted into law in 2004.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
LEGISLATION

Integrating Support Programs for Efficiency
This Act is designed to transform the state older adult services system into a primarily home- and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services. It encompasses the housing, health, financial and other supportive older adult services.

Submitted as:
Illinois
Public Act 93-1031
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “The Older Adult Services Act.”

Section 2. [Purpose.] The purpose of this Act is to transform [this state’s] comprehensive system of older adult services from a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services. Such restructuring shall encompass the provision of housing, health, financial, and supportive older adult services. It is envisioned that this restructuring will promote the development, availability, and accessibility of a comprehensive, affordable, and sustainable service delivery system that places a high priority on home-based and community-based services. Such restructuring will encompass all aspects of the delivery system regardless of the setting in which the service is provided.

Section 3. [Definitions.] As used in this Act:
“Advisory Committee” means the [Older Adult Services Advisory Committee].
“Certified nursing home” means any nursing home licensed under the [insert citation] and certified under Title XIX of the Social Security Act to participate as a vendor in the medical assistance program under [insert citation].
“Comprehensive case management” means the assessment of needs and preferences of an older adult at the direction of the older adult or the older adult’s designated representative and the arrangement, coordination, and monitoring of an optimum package of services to meet the needs of the older adult.
“Consumer-directed” means decisions made by an informed older adult from available services and care options, which may range from independently making all decisions and managing services directly to limited participation in decision-making, based upon the functional and cognitive level of the older adult.
“Coordinated point of entry” means an integrated access point where consumers receive information and assistance, assessment of needs, care planning, referral, assistance in completing applications, authorization of services where permitted, and follow-up to ensure that referrals and services are accessed.
“Department” means the [Department on Aging], in collaboration with the departments of [Public Health and Public Aid] and other relevant agencies and in consultation with the Advisory Committee, except as otherwise provided.

“Departments” means the [Department on Aging], the [departments of Public Health and Public Aid], and other relevant agencies in collaboration with each other and in consultation with the [Advisory Committee], except as otherwise provided.

“Family caregiver” means an adult family member or another individual who is an uncompensated provider of home-based or community-based care to an older adult.

“Health services” means activities that promote, maintain, improve, or restore mental or physical health or that are palliative in nature.

“Older adult” means a person age [60] or older and, if appropriate, the person’s family caregiver.

“Person-centered” means a process that builds upon an older adult’s strengths and capacities to engage in activities that promote community life and that reflect the older adult’s preferences, choices, and abilities, to the extent practicable.

“Priority service area” means an area identified by the [Departments] as being less-served with respect to the availability of and access to older adult services in [this state]. The [Departments] shall determine by rule the criteria and standards used to designate such areas.

“Priority service plan” means the plan developed pursuant to Section 5 of this Act.

“Provider” means any supplier of services under this Act.

“Residential setting” means the place where an older adult lives.

“Restructuring” means the transformation of [this state’s] comprehensive system of older adult services from funding primarily a facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services.

“Services” means the range of housing, health, financial, and supportive services, other than acute health care services, that are delivered to an older adult with functional or cognitive limitations, or socialization needs, who requires assistance to perform activities of daily living, regardless of the residential setting in which the services are delivered.

“Supportive services” means non-medical assistance given over a period of time to an older adult that is needed to compensate for the older adult’s functional or cognitive limitations, or socialization needs, or those services designed to restore, improve, or maintain the older adult’s functional or cognitive abilities.

Section 4. [Designation of Lead Agency; Annual Report.]
(a) The [Department on Aging] shall be the lead agency for: the provision of services to older adults and their family caregivers; restructuring [this state’s] service delivery system for older adults; and the implementation of this Act, except where otherwise provided. The [Department on Aging] shall collaborate with the [departments of Public Health and Public Aid] and any other relevant agencies, and shall consult with the [Advisory Committee], in all aspects of these duties, except as otherwise provided in this Act.
(b) The [Departments] shall promulgate rules to implement this Act pursuant to [insert citation].
(c) On [January 1, 2006], and each [January 1 thereafter], the [Department] shall issue a report to the [General Assembly] on progress made in complying with this Act, impediments thereto, recommendations of the [Advisory Committee], and any recommendations for
legislative changes necessary to implement this Act. To the extent practicable, all reports required by this Act shall be consolidated into a single report.

Section 5. [Priority Service Areas; Service Expansion.]

(a) The requirements of this Section are subject to the availability of funding.

(b) The [Department] shall expand older adult services that promote independence and permit older adults to remain in their own homes and communities. Priority shall be given to both the expansion of services and the development of new services in priority service areas.

(c) Inventory of services. The [Department] shall develop and maintain an inventory and assessment of the types and quantities of public older adult services and, to the extent possible, privately provided older adult services, including the unduplicated count, location, and characteristics of individuals served by each facility, program, or service and the resources supporting those services.

(d) Priority service areas. The [Departments] shall assess the current and projected need for older adult services throughout the State, analyze the results of the inventory, and identify priority service areas, which shall serve as the basis for a priority service plan to be filed with the [Governor] and the [General Assembly] no later than [July 1, 2006], and every [5 years] thereafter.

(e) Moneys appropriated by the [General Assembly] for the purpose of this Section, receipts from donations, grants, fees, or taxes that may accrue from any public or private sources to the [Department] for the purpose of this Section, and savings attributable to the nursing home conversion program as calculated in subsection (h) shall be deposited into the [Department on Aging State Projects Fund]. Interest earned by those moneys in the [Fund] shall be credited to the [Fund].

(f) Moneys described in subsection (e) from the [Department on Aging State Projects Fund] shall be used for older adult services, regardless of where the older adult receives the service, with priority given to both the expansion of services and the development of new services in priority service areas. Fundable services shall include:

1. Housing, health services, and supportive services:
   (A) adult day care;
   (B) adult day care for persons with Alzheimer’s disease and related disorders;
   (C) activities of daily living;
   (D) care-related supplies and equipment;
   (E) case management;
   (F) community reintegration;
   (G) companion;
   (H) congregate meals;
   (I) counseling and education;
   (J) elder abuse prevention and intervention;
   (K) emergency response and monitoring;
   (L) environmental modifications;
   (M) family caregiver support;
   (N) financial;
   (O) home delivered meals;
   (P) homemaker;
(Q) home health;
(R) hospice;
(S) laundry;
(T) long-term care ombudsman;
(U) medication reminders;
(V) money management;
(W) nutrition services;
(X) personal care;
(Y) respite care;
(Z) residential care;
(AA) senior benefits outreach;
(BB) senior centers;
(CC) services provided under the [insert citation], or sheltered care
services that meet the requirements of the [insert citation];
(DD) telemedicine devices to monitor recipients in their own homes as an
alternative to hospital care, nursing home care, or home visits;
(EE) training for direct family caregivers;
(FF) transition;
(GG) transportation;
(HH) wellness and fitness programs; and
(II) other programs designed to assist older adults to remain independent
and receive services in the most integrated residential setting possible for that person.
(2) Older Adult Services Demonstration Grants, pursuant to subsection (l) of this
Section.

(g) Older Adult Services Demonstration Grants. The [Department] shall establish a
program of demonstration grants to assist in the restructuring of the delivery system for older
adult services and provide funding for innovative service delivery models and system change
and integration initiatives. The [Department] shall prescribe, by rule, the grant application
process. At a minimum, every application must include:
(1) The type of grant sought;
(2) A description of the project;
(3) The objective of the project;
(4) The likelihood of the project meeting identified needs;
(5) The plan for financing, administration, and evaluation of the project;
(6) The timetable for implementation;
(7) The roles and capabilities of responsible individuals and organizations;
(8) Documentation of collaboration with other service providers, local community
government leaders, and other stakeholders, other providers, and any other stakeholders in the
community;
(9) Documentation of community support for the project, including support by
other service providers, local community government leaders, and other stakeholders;
(10) The total budget for the project;
(11) The financial condition of the applicant; and
(12) Any other application requirements that may be established by the
[Department] by rule.
(h) Each project may include provisions for a designated staff person who is responsible for the development of the project and recruitment of providers.

(i) Projects may include, but are not limited to: adult family foster care; family adult day care; assisted living in a supervised apartment; personal services in a subsidized housing project; evening and weekend home care coverage; small incentive grants to attract new providers; money following the person; cash and counseling; managed long-term care; and at least one respite care project that establishes a local coordinated network of volunteer and paid respite workers, coordinates assignment of respite workers to caregivers and older adults, ensures the health and safety of the older adult, provides training for caregivers, and ensures that support groups are available in the community.

(j) A demonstration project funded in whole or in part by an Older Adult Services Demonstration Grant is exempt from the requirements of [insert citation]. To the extent applicable, however, for the purpose of maintaining the statewide inventory authorized by the [insert citation], the [Department] shall send to the [Health Facilities Planning Board] a copy of each grant award made under this subsection (g).

(k) The [Department], in collaboration with the [Departments of Public Health and Public Aid], shall evaluate the effectiveness of the projects receiving grants under this Section.

(l) No later than [July 1] of each year, the [Department of Public Health] shall provide information to the [Department of Public Aid] to enable the [Department of Public Aid] to [annually] document and verify the savings attributable to the nursing home conversion program for the previous fiscal year to estimate an annual amount of such savings that may be appropriated to the [Department on Aging State Projects Fund] and notify the [General Assembly], the [Department of Aging], the [Department of Human Services], and the [Advisory Committee] of the savings no later than [October 1] of the same fiscal year.

Section 6. [Older Adult Services Restructuring.] No later than [January 1, 2005], the [Department] shall commence the process of restructuring the older adult services delivery system. Priority shall be given to both the expansion of services and the development of new services in priority service areas. Subject to the availability of funding, the restructuring shall include, but not be limited to, the following:

(1) Planning. The [Department] shall develop a plan to restructure the State’s service delivery system for older adults. The plan shall include a schedule for the implementation of the initiatives outlined in this Act and all other initiatives identified by the participating agencies to fulfill the purposes of this Act. Financing for older adult services shall be based on the principle that “money follows the individual.” The plan shall also identify potential impediments to delivery system restructuring and include any known regulatory or statutory barriers.

(2) Comprehensive case management. The [Department] shall implement a statewide system of holistic comprehensive case management. The system shall include the identification and implementation of a universal, comprehensive assessment tool to be used statewide to determine the level of functional, cognitive, socialization, and financial needs of older adults. This tool shall be supported by an electronic intake, assessment, and care planning system linked to a central location. “Comprehensive case management” includes services and coordination such as (i) comprehensive assessment of the older adult (including the physical, functional, cognitive, psycho-social, and social needs of the individual); (ii) development and implementation of a service plan with the older adult to mobilize the formal and family resources
and services identified in the assessment to meet the needs of the older adult, including
coordination of the resources and services with any other plans that exist for various formal
services, such as hospital discharge plans, and with the information and assistance services; (iii)
coordination and monitoring of formal and family service delivery, including coordination and
monitoring to ensure that services specified in the plan are being provided; (iv) periodic
reassessment and revision of the status of the older adult with the older adult or, if necessary, the
older adult’s designated representative; and (v) in accordance with the wishes of the older adult,
avocacy on behalf of the older adult for needed services or resources.

(3) Coordinated point of entry. The [Department] shall implement and publicize a
statewide coordinated point of entry using a uniform name, identity, logo, and toll-free number.

(4) Public web site. The [Department] shall develop a public web site that
provides links to available services, resources, and reference materials concerning caregiving,
diseases, and best practices for use by professionals, older adults, and family caregivers.

(5) Expansion of older adult services. The [Department] shall expand older adult
services that promote independence and permit older adults to remain in their own homes and
communities.

(6) Consumer-directed home and community-based services. The [Department] shall expand the range of service options available to permit older adults to exercise maximum
choice and control over their care.

(7) Comprehensive delivery system. The [Department] shall expand opportunities
for older adults to receive services in systems that integrate acute and chronic care.

(8) Enhanced transition and follow-up services. The [Department] shall
implement a program of transition from one residential setting to another and follow-up services,
regardless of residential setting, pursuant to rules with respect to (i) resident eligibility, (ii)
assessment of the resident’s health, cognitive, social, and financial needs, (iii) development of
transition plans, and (iv) the level of services that must be available before transitioning a
resident from one setting to another.

(9) Family caregiver support. The [Department] shall develop strategies for public
and private financing of services that supplement and support family caregivers.

(10) Quality standards and quality improvement. The [Department] shall establish
a core set of uniform quality standards for all providers that focus on outcomes and take into
c consideration consumer choice and satisfaction, and the [Department] shall require each provider
to implement a continuous quality improvement process to address consumer issues. The
continuous quality improvement process must benchmark performance, be person-centered and
data-driven, and focus on consumer satisfaction.

(11) Workforce. The [Department] shall develop strategies to attract and retain a
qualified and stable worker pool, provide living wages and benefits, and create a work
environment that is conducive to long-term employment and career development. Resources
such as grants, education, and promotion of career opportunities may be used.

(12) Coordination of services. The [Department] shall identify methods to better
cordinate service networks to maximize resources and minimize duplication of services and
ease of application.

(13) Barriers to services. The [Department] shall identify barriers to the provision,
availability, and accessibility of services and shall implement a plan to address those barriers.
The plan shall: (i) identify barriers, including but not limited to, statutory and regulatory
complexity, reimbursement issues, payment issues, and labor force issues; (ii) recommend
changes to State or federal laws or administrative rules or regulations; (iii) recommend application for federal waivers to improve efficiency and reduce cost and paperwork; (iv) develop innovative service delivery models; and (v) recommend application for federal or private service grants.

(14) Reimbursement and funding. The [Department] shall investigate and evaluate costs and payments by defining costs to implement a uniform, audited provider cost reporting system to be considered by all [Departments] in establishing payments. To the extent possible, multiple cost reporting mandates shall not be imposed.

(15) Medicaid nursing home cost containment and Medicare utilization. The [Department of Public Aid], in collaboration with the [Department on Aging and the Department of Public Health] and in consultation with the [Advisory Committee], shall propose a plan to contain Medicaid nursing home costs and maximize Medicare utilization. The plan must not impair the ability of an older adult to choose among available services. The plan shall include, but not be limited to, (i) techniques to maximize the use of the most cost-effective services without sacrificing quality and (ii) methods to identify and serve older adults in need of minimal services to remain independent, but who are likely to develop a need for more extensive services in the absence of those minimal services.

(16) Bed reduction. The [Department of Public Health] shall implement a nursing home conversion program to reduce the number of Medicaid-certified nursing home beds in areas with excess beds. The [Department of Public Aid] shall investigate changes to the Medicaid nursing facility reimbursement system in order to reduce beds. Such changes may include, but are not limited to, incentive payments that will enable facilities to adjust to the restructuring and expansion of services required by the Older Adult Services Act, including adjustments for the voluntary closure or layaway of nursing home beds certified under Title XIX of the federal Social Security Act. Any savings shall be reallocated to fund home-based or community-based older adult services pursuant to Section 5 of this Act.

(17) Financing. The [Department] shall investigate and evaluate financing options for older adult services and shall make recommendations in the report required by Section 4 concerning the feasibility of these financing arrangements. These arrangements shall include, but are not limited to:

- (A) private long-term care insurance coverage for older adult services;
- (B) enhancement of federal long-term care financing initiatives;
- (C) employer benefit programs such as medical savings accounts for long-term care;
- (D) individual and family cost-sharing options;
- (E) strategies to reduce reliance on government programs;
- (F) fraudulent asset divestiture and financial planning prevention; and
- (G) methods to supplement and support family and community caregiving.

(18) Older Adult Services Demonstration Grants. The [Department] shall implement a program of demonstration grants that will assist in the restructuring of the older adult services delivery system, and shall provide funding for innovative service delivery models and system change and integration initiatives pursuant to subsection (g) of Section 5.

(19) Bed Need Methodology Update. For the purposes of determining areas with excess beds, the [Departments] shall provide information and assistance to the [Health Facilities Planning Board] to update the [Bed Need Methodology for Long-Term Care] to update the
assumptions used to establish the methodology to make them consistent with modern older adult services.

Section 7. [Nursing Home Conversion Program.]

(a) The [Department of Public Health], in collaboration with the [Department on Aging and the Department of Public Aid], shall establish a nursing home conversion program. Start-up grants, pursuant to subsections (l) and (m) of this Section, shall be made available to nursing homes as appropriations permit as an incentive to reduce certified beds, retrofit, and retool operations to meet new service delivery expectations and demands.

(b) Grant moneys shall be made available for capital and other costs related to:

(1) the conversion of all or a part of a nursing home to an assisted living establishment or a special program or unit for persons with Alzheimer’s disease or related disorders licensed under the [insert citation] or a supportive living facility established under [insert citation]

(2) the conversion of multi-resident bedrooms in the facility into single-occupancy rooms; and

(3) the development of any of the services identified in a priority service plan that can be provided by a nursing home within the confines of a nursing home or transportation services. Grantees shall be required to provide a minimum of a [20 percent] match toward the total cost of the project.

(c) Nothing in this Act shall prohibit the co-location of services or the development of multifunctional centers under subsection (f) of Section e of this Act, including a nursing home offering community-based services or a community provider establishing a residential facility.

(d) A certified nursing home with at least [50 percent] of its resident population having their care paid for by the Medicaid program is eligible to apply for a grant under this Section.

(e) Any nursing home receiving a grant under this Section shall reduce the number of certified nursing home beds by a number equal to or greater than the number of beds being converted for one or more of the permitted uses under item (1) or (2) of subsection (b). The nursing home shall retain the Certificate of Need for its nursing and sheltered care beds that were converted for [15 years]. If the beds are reinstated by the provider or its successor in interest, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant. The Department shall establish, by rule, the bed reduction methodology for nursing homes that receive a grant pursuant to item (3) of subsection (b).

(f) Any nursing home receiving a grant under this Section shall agree that, for a minimum of [10 years] after the date that the grant is awarded, a minimum of [50 percent] of the nursing home’s resident population shall have their care paid for by the Medicaid program. If the nursing home provider or its successor in interest ceases to comply with the requirement set forth in this subsection, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant.

(g) Before awarding grants, the [Department of Public Health] shall seek recommendations from the [Department on Aging and the Department of Public Aid]. The [Department of Public Health] shall attempt to balance the distribution of grants among geographic regions, and among small and large nursing homes. The [Department of Public Health] shall develop, by rule, the criteria for the award of grants based upon the following factors:
(1) the unique needs of older adults (including those with moderate and low incomes), caregivers, and providers in the geographic area of the State the grantee seeks to serve;
(2) whether the grantee proposes to provide services in a priority service area;
(3) the extent to which the conversion or transition will result in the reduction of certified nursing home beds in an area with excess beds;
(4) the compliance history of the nursing home; and
(5) any other relevant factors identified by the [Department], including standards of need.

(h) A conversion funded in whole or in part by a grant under this Section must not:
(1) diminish or reduce the quality of services available to nursing home residents;
(2) force any nursing home resident to involuntarily accept home-based or community-based services instead of nursing home services;
(3) diminish or reduce the supply and distribution of nursing home services in any community below the level of need, as defined by the [Department] by rule; or
(4) cause undue hardship on any person who requires nursing home care.

(i) The [Department] shall prescribe, by rule, the grant application process. At a minimum, every application must include:
(1) the type of grant sought;
(2) a description of the project;
(3) the objective of the project;
(4) the likelihood of the project meeting identified needs;
(5) the plan for financing, administration, and evaluation of the project;
(6) the timetable for implementation;
(7) the roles and capabilities of responsible individuals and organizations;
(8) documentation of collaboration with other service providers, local community government leaders, and other stakeholders, other providers, and any other stakeholders in the community;
(9) documentation of community support for the project, including support by other service providers, local community government leaders, and other stakeholders;
(10) the total budget for the project;
(11) the financial condition of the applicant; and
(12) any other application requirements that may be established by the [Department] by rule.

(j) A conversion project funded in whole or in part by a grant under this Section is exempt from the requirements of [insert citation]. The [Department of Public Health], however, shall send to the [Health Facilities Planning Board] a copy of each grant award made under this Section.

(k) Applications for grants are public information, except that nursing home financial condition and any proprietary data shall be classified as nonpublic data.

(l) The [Department of Public Health] may award grants from the [Long Term Care Civil Money Penalties Fund] established under Section 1919(h)(2)(A)(ii) of the Social Security Act and 42 CFR 488.422(g) if the award meets federal requirements.

Section 8. [Older Adult Services Advisory Committee.]
(a) The [Older Adult Services Advisory Committee] is created to advise the [directors of Aging, Public Aid, and Public Health] on all matters related to this Act and the delivery of services to older adults in general.

(b) The [Advisory Committee] shall be comprised of the following:

1. The [Director of Aging] or his or her designee, who shall serve as chair and shall be an ex officio and nonvoting member.

2. The [Director of Public Aid] and the [Director of Public Health] or their designees, who shall serve as vice-chairs and shall be ex officio and nonvoting members.

3. One representative each of the [Governor’s Office, the Department of Public Aid, the Department of Public Health, the Department of Veterans’ Affairs, the Department of Human Services, the Department of Insurance, the Department of Commerce and Economic Opportunity, the Department on Aging, the Department on Aging’s State Long Term Care Ombudsman, the Housing Finance Authority, and the Housing Development Authority], each of whom shall be selected by his or her respective director and shall be an ex officio and nonvoting member.

4. Thirty-two members appointed by the [Director of Aging] in collaboration with the [directors of Public Health and Public Aid], and selected from the recommendations of statewide associations and organizations, as follows:

   A. [One] member representing the [Area Agencies on Aging];

   B. [Four] members representing nursing homes or licensed assisted living establishments;

   C. [One] member representing home health agencies;

   D. [One] member representing case management services;

   E. [One] member representing statewide senior center associations;

   F. [One] member representing [Community Care Program homemaker services];

   G. [One] member representing [Community Care Program adult day related dementias];

   H. [One] member representing nutrition project directors;

   I. [One] member representing hospice programs;

   J. [One] member representing individuals with Alzheimer’s disease and nursing;

   K. [Two] members representing statewide trade or labor unions;

   L. [One] advanced practice nurse with experience in gerontological advocacy or legal representation on behalf of the senior population;

   M. [One] physician specializing in gerontology;

   N. [One] member representing regional long-term care ombudsmen;

   O. [One] member representing township officials;

   P. [One] member representing municipalities;

   Q. [One] member representing county officials;

   R. [One] member representing the parish nurse movement;

   S. [One] member representing pharmacists;

   T. [Two] members representing statewide organizations engaging in advocacy or legal representation on behalf of the senior population;

   U. [Two] family caregivers;

   V. [Two] citizen members over the age of [60];
(W) [One] citizen with knowledge in the area of gerontology research or health care law;

(X) [One] representative of health care facilities licensed under the [Hospital Licensing Act]; and

(Y) [One] representative of primary care service providers.

(c) Voting members of the [Advisory Committee] shall serve for a term of [3 years] or until a replacement is named. All members shall be appointed no later than [January 1, 2005]. Of the initial appointees, as determined by lot, [10 members shall serve a term of one year]; [10 shall serve for a term of 2 years]; and [12 shall serve for a term of 3 years]. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of that term. [The Advisory Committee] shall meet at least quarterly and may meet more frequently at the call of the Chair. A simple majority of those appointed shall constitute a quorum. The affirmative vote of a majority of those present and voting shall be necessary for [Advisory Committee] action. Members of the [Advisory Committee] shall receive no compensation for their services.

(d) The [Advisory Committee] shall have an [Executive Committee] comprised of the [Chair, the Vice Chairs, and up to 15 members of the Advisory Committee appointed by the Chair] who have demonstrated expertise in developing, implementing, or coordinating the system restructuring initiatives defined in Section 6 of this Act. The [Executive Committee] shall have responsibility to oversee and structure the operations of the [Advisory Committee] and to create and appoint necessary subcommittees and subcommittee members.

(e) The [Advisory Committee] shall study and make recommendations related to the implementation of this Act, including but not limited to system restructuring initiatives as defined in Section 6 of this Act or otherwise related to this Act.

Section 9. [Severability.] [Insert severability clause.]

Section 10. [Repealer.] [Insert repealer clause.]

Section 11. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS

(   ) Include in 2008 Supplement

(   ) Reject

Comments/Note to staff:
This Act directs the state Commissioner of Health and the state Commissioner of the Department for the Aging to develop a single application form for citizens to use to seek eligibility for various pharmaceutical assistance programs and pharmaceutical discount purchasing cards. The Commissioners must obtain copies of the application forms used by such pharmaceutical assistance programs and pharmaceutical discount purchasing cards in the state, compile a list of the various information required to complete such application forms, identify common elements, and analyze the forms for readability and simplicity. Upon completion of this analysis, the Commissioners must then design a single, concise application form that is logically formatted, written in clear and easily comprehensible language, and covers any and all data that may be required to obtain eligibility for any such pharmaceutical assistance program or pharmaceutical discount purchasing card. Upon completion of the design for the single concise application form for pharmaceutical assistance programs and pharmaceutical discount purchasing cards in the state, the Commissioners must place such application form on their respective departments’ websites and cooperate with the programs and pharmaceutical companies to encourage the use of the design throughout the state. In order to perform the duties provided in the new subsection, the Commissioners may appoint an advisory task force of stakeholders to assist them in this endeavor.

Submitted as:
Virginia
Chapter 318, 2004
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)
Commissioner of the Department for the Aging] shall disseminate information to the public concerning recent congressional actions relating to pharmaceutical benefits to be provided under the Medicare program and how such benefits may help senior citizens with the costs of pharmaceutical benefits.

D. The [Commissioner] shall establish a toll-free telephone number, to be administered by the [Department of Health], which shall provide recorded information concerning services available from the [Department for the Aging], the [state Agencies on Aging], and other appropriate organizations for senior citizens.

E. The [Commissioner of Health and the Commissioner of the Department for the Aging] shall develop a strategy, in coordination with the [state Agencies on Aging] and other private and nonprofit organizations, for disseminating information to the public concerning the availability of pharmaceutical assistance programs and for training senior citizen volunteers to assist in completing applications for pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

Section 3. [Application Forms.] In addition to the responsibilities set forth in Section 2 of this Act, the [Commissioner of Health and the Commissioner of the Department for the Aging] shall encourage pharmaceutical manufacturers to include application forms for pharmaceutical discount purchasing card programs on their respective websites in a format capable of being downloaded and printed by consumers. When practicable, the website maintained by the [Department for the Aging] shall include direct links to such forms.

Section 4. [Feasibility and Standards for Developing a Single Application Form.]

A. The [Commissioner of Health and the Commissioner of the Department for the Aging] shall report to the [Governor] and [General Assembly] by [October 30, 2004], on the feasibility of developing a single application form for residents of this state to use to seek eligibility for the [nearly 50] pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

B. In determining feasibility, the [Commissioners] shall obtain copies of the application forms used by such pharmaceutical assistance programs and pharmaceutical discount purchasing cards in this state. [Commissioners] should review and analyze such forms, and their analysis should include but not be limited to:

(1) compiling a list of the various information required to complete such application forms;
(2) identifying common elements; and
(3) analyzing the forms for readability and simplicity.

C. Upon completion of this analysis, the [Commissioners] shall assess the feasibility of designing a single, concise application form that is logically formatted, written in clear and easily comprehensible language, and covers any and all data that may be required to obtain eligibility for any such pharmaceutical assistance program or pharmaceutical discount purchasing card.

D. To assist them in completing the responsibilities set forth in subsections A and B of this section, the [Commissioners] may appoint an advisory task force of stakeholders.

Section 5. [Severability.] [Insert severability clause.]

Section 6. [Repealer.] [Insert repealer clause.]

Section 7. [Effective Date.] [Insert effective date.]
Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act establishes a council and committee to set up a statewide stroke emergency transportation plan and to develop criteria for a stroke facility. The stroke emergency transport plan must include:

- Training requirements on stroke recognition and treatment, including emergency screening procedures;
- A list of appropriate early treatments to stabilize patients;
- Protocols for rapid transport to a stroke facility when rapid transport is appropriate and it is safe to bypass another health care facility; and
- Plans for coordination with statewide agencies or committees on programs for stroke prevention and community education regarding stroke and stroke emergency transport.

Submitted as:
Texas
SB 330
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
The Act creates a senior services board to make grants and awards to innovative programs that provide services to the state’s elderly population.

Submitted as:
Wyoming
HB0058 / Act 131
Status: Enacted into law in 2003.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
LEGISLATION

State Approaches to Caregiving
26-28AS-13 Long-Term Care Partnership Program (2006 SSL)

This Act directs the state department of health to disregard or not count benefits from certain long term care insurance policies as assets under the state Medicaid program.

Submitted as:
Idaho
HB658 (Enrolled Version)
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “The Long-Term Care Partnership Program.”

Section 2. [Definitions.] As used in this Act:

1. “Asset disregard” means the total assets an individual can own and maintain under Medicaid and still qualify for benefits at the time the individual applies for benefits:
   a. If the individual is a beneficiary of a Long-Term Care Partnership Program approved policy; and
   b. Has exhausted the benefits of the policy.

2. “Department” means the state [department of health and welfare].

3. “Long-Term Care Partnership program approved policy” means a long-term care insurance policy which is approved by the state [department of insurance] and is provided through state approved long-term care insurers through the Long-Term Care Partnership Program.

4. “Medicaid” means the Federal Medical Assistance Program established under Title XIX of the Social Security Act.

Section 3. [Long-Term Care Partnership Program.]

1. This Act hereby establishes a Long-Term Care Partnership Program, to be administered by the [department] with the assistance of the [department of insurance]. The Long-Term Care Partnership Program shall:
   a. Provide incentives for people to insure against the costs of providing for their long-term care needs;
   b. Provide a mechanism for people to qualify for coverage of the cost of their long term care needs under Medicaid without first being required to substantially exhaust their resources;
   c. Provide counseling services to people who are planning for their long-term care needs; and
   d. Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.
Upon exhausting benefits under a Long-Term Care Partnership Program policy, certain resources of an individual, as described in subsection (3) of this section, shall not be considered by the [department] as a determination of any of the following:

(a) Eligibility for Medicaid;
(b) Amount of any Medicaid payment; or
(c) Any subsequent recovery by the state of a payment for medical services.

The [department] shall promulgate necessary rules and amendments to the state plan to allow for asset disregard. To provide asset disregard, for purchasers of a Long-Term Care Partnership Program policy, the [department] shall count insurance benefits paid under the policy toward asset disregard to the extent the payments are for covered services under the Long-Term Care Partnership Program policy.

Section 4. [Eligibility.]

(1) An individual who is a beneficiary of a Long-Term Care Partnership Program policy is eligible for assistance under Medicaid using the asset disregard under Section 3 of this Act.

(2) If the Long-Term Care Partnership Program is discontinued, an individual who purchased a Long-Term Care Partnership Policy prior to the date the Program is discontinued shall be eligible to receive asset disregard.

(3) The [department] may enter into reciprocal agreements with other states to extend the asset disregard to residents of the state who purchased long-term care policies in another state which has a substantially similar asset disregard program to the program under Section 3 of this Act.

Section 5. [Administration.] The [department] and the state [department of insurance] are authorized to adopt rules to implement the provisions of this Act for its administration.

Section 6. [Notice.]

(1) A long-term care insurance policy issued after the effective date of this Act shall contain a notice provision to the consumer detailing in plain language the current law pertaining to asset disregard and asset tests.

(2) The notice to the consumer under subsection (1) of this section shall be developed by the [director of the department of insurance].

Section 7. [Severability.] [Insert severability clause.]

Section 8. [Repealer.] [Insert repealer clause.]

Section 9. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-14 Pooled Trusts for People with Disabilities (2004 SSL)

This Act enables people with disabilities to pool their assets into a common trust to help generate income without having to count the interest earned from the joint trust assets against their eligibility requirements for state medical assistance.

Submitted as:
Pennsylvania
Chapter 168 of 2002
Status: Enacted into law in 2002.

Suggested State Legislation

 İstanbul 2008 SSL Supplement - Aging
(b) Fiduciary Status of Board -- The members of a board and employees of a
trustee, if any, shall stand in a fiduciary relationship to the beneficiaries and the trustee
regarding investment of the trust and shall not profit, either directly or indirectly, with
respect thereto.

(c) Control and Management -- A trustee shall maintain a separate account for
each beneficiary of a pooled trust, but for purposes of investment and management of
funds, the trustee may pool these accounts. The trustee shall have exclusive control and
authority to manage and invest the money in the pooled trust in accordance with this
section, subject, however, to the exercise of that degree of judgment, skill and care under
the prevailing circumstances that a person of prudence, discretion and intelligence, who
are familiar with investment matters, exercise in the management of their affairs,
considering the probable income to be derived from the investment and the probable
safety of their capital. The trustee may charge a trust management fee to cover the costs
of administration and management of the pooled trust.

(d) Conflict of Interest -- A board member shall disclose and abstain from
participation in a discussion or voting on an issue when a conflict of interest arises with
the board member on a particular issue or vote.

(e) Compensation -- No board member may receive compensation for services
provided as a member of the board. No fees or commissions may be paid to a board
member. A board member may be reimbursed for necessary expenses incurred which are
in the best interest of the beneficiaries of the pooled trust as a board member upon
presentation of receipts.

(f) Disbursements -- The trustee shall disburse money from a beneficiary’s
account only on behalf of the beneficiary. A disbursement from a beneficiary’s account
shall be in the best interest of the beneficiary.

Section 4. [Pooled Trust Fund.] All money received for pooled trust funds shall
be deposited with a court-approved corporate fiduciary or with the [State Treasury] if no
court-approved corporate fiduciary is available to the trustee. The funds shall be pooled
for investment and management. A separate account shall be maintained for each
beneficiary, and quarterly accounting statements shall be provided to each beneficiary by
the trustee. The court-approved corporate fiduciary or the [State Treasury] shall provide
quarterly accounting statements to the trustee. The court-approved corporate fiduciary or
the [State Treasury] may charge a trust management fee to cover the costs of managing
the funds in the pooled trust.

Section 5. [Reporting.]

(a) Preparation and Filing of Annual Financial Report -- In addition to reports
required to be filed under [insert citation relating to partnerships and limited liability
companies], the trustee shall file an annual report with the [Office Of Attorney General]
along with an itemized statement which shows the funds collected for the year, income
earned, salaries paid, other expenses incurred and the opening and final trust balances. A
copy of this statement shall be available to the beneficiary, trustor or designee of the
trustor, upon request.

(b) Preparation of Annual Beneficiary’s Report -- The trustee shall prepare and
provide each trustor or the trustor’s designee annually with a detailed individual
statement of the services provided to the trustor’s beneficiary during the previous 12 months and of the services to be provided during the following 12 months. The trustee shall provide a copy of this statement to the beneficiary, upon request.

Section 6. [Coordination of Services.]
(a) Medical Assistance -- In the determination of eligibility for medical assistance benefits, the interest of any disabled beneficiary in a pooled trust shall not be considered as a resource for purposes of determining the beneficiary’s eligibility for medical assistance.
(b) Reductions -- No State agency shall reduce the benefits or services available to an individual because that person is a beneficiary of a pooled trust. The beneficiary’s interest in a pooled trust shall not be reachable in satisfaction of a claim for support and maintenance of the beneficiary.

Section 7. [Notice.] The [Office of the Attorney General] shall make available information on the treatment of pooled trusts to the people with disabilities in the medical assistance program.

Section 8. [Applicability.] This Act shall apply to pooled trusts established on or after the effective date of this Act and to the accounts of individual beneficiaries established on or after the effective date of this Act in pooled trusts created before the effective date of this Act.

Section 9. [Severability.] [Insert severability clause.]

Section 10. [Repealer.] [Insert repealer clause.]

Section 11. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act establishes programs and services to ensure consumers have access to a well-coordinated, comprehensive, adequately funded and dynamic array of long-term services and supports including but not limited to assessment, care planning, in-home services and supports, a range of assisted living options, care management services, respite care services, nursing facility care, hospice care, primary care, chronic care management, supports coordination, and acute care. This array of services and supports must be designed through a person-centered planning process to meet existing consumer needs and preferences, be flexible and responsive to changing consumer needs and preferences, and encourage innovation and quality long-term care.

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Sec. 1 [Short Title.] This act shall be known and may be cited as the “Michigan Long-Term Care Consumer Choice and Quality Improvement Act.”

Sec. 2 [Definitions.]

(1) Definitions: When used in this Act, the following words shall have the following meanings:

(a) “Authority” means the entity created pursuant to section 4 of this Act.
(b) “Commission” means the long-term care commission established pursuant to section 3 of this act.
(c) “Consumer” means an individual seeking or receiving public assistance for long-term care.
(d) “Department” means the department of community health.
(e) “Director” means the director of the department.
(f) “Long-term care” means those services and supports provided to an individual in a setting of his or her choice that are evaluative, preventive, rehabilitative, or health related in nature.
(g) “Medicaid” means the program for medical assistance established under title XIX of the Social Security Act, Chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the Social Welfare Act, 1939 PA 280, MCL 400.1 to 400.119b.
(h) “Person-centered planning” means a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
(i) “Primary consumer” means the actual user of long-term care services.
(j) “Secondary consumer” means family members or unpaid caregivers of consumers.
(k) “Single points of entry” means those entities created pursuant to section 6 of this act.
"Transition services" means those services provided to assist an individual in moving from one setting to another setting of his or her choice and may include, but is not limited to, the payment of security deposits, moving expenses, purchase of essential furnishings, and purchase of durable medical equipment.

Sec. 3 [Findings and Purpose.]

(1) The legislature finds that long-term care services and supports are critically important for Michigan citizens, their families, caregivers and communities, that the need for long-term care services and supports is expected to increase substantially as the number of older people and people with disabilities increases, that consumers will be best served by the creation and continuing refinement of a carefully coordinated long-term care system that promotes healthy aging, consumer education and choice, innovation, quality, dignity, autonomy, the efficient and effective allocation of resources in response to consumer needs and preferences, and the opportunity for all long-term care consumers, regardless of their age or source of payment, to develop and maintain their fullest human potential.

(2) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VII of the state constitution of 1963, which declares that services for the care, treatment, education or rehabilitation of persons with disabilities shall always be fostered and supported, the department is charged with the primary responsibility for ensuring the development and availability of a system of long-term care as described in this Act.

(3) The purpose of this Act is to ensure all of the following:

(a) That consumers have access to a well-coordinated, comprehensive, adequately funded and dynamic array of long-term services and supports including but not limited to assessment, care planning, in-home services and supports, a range of assisted living options, care management services, respite care services, nursing facility care, hospice care, primary care, chronic care management, supports coordination, and acute care. This array of services and supports must be designed through a person-centered planning process to meet existing consumer needs and preferences, be flexible and responsive to changing consumer needs and preferences, and encourage innovation and quality;

(b) That consumers are provided with sufficient education and support to make informed choices about their long-term care service and supports options;

(c) That the system is consumer focused, embraces person centered planning, and fosters the creation of innovative long-term care options;

(d) That services and supports are provided in the most independent living setting be consistent with the consumer’s needs and preferences;

(e) That access to long-term care services and supports is determined by a uniform system for comprehensively assessing abilities and needs;

(f) That public resources purchase, permit, and promote high quality settings, services, and supports through:

(1) adequate and consistent monitoring of publicly funded settings, services and supports;

(2) consistent and appropriate enforcement of statutory and regulatory standards;

(3) monitoring of outcomes of long-term care for quality and adherence to the consumers’ expressed preferences; and
(4) swift and effective remedies if services, supports, or settings fail to meet quality standards or to promote long-term care consumers’ dignity, autonomy, and choice.

(g) The goal of the system shall be continuous quality improvement focused on consumer satisfaction and the consistent achievement of clear standards concerning the health, safety, autonomy, and dignity of long-term care managers; family members; and others when appropriate. These mechanisms shall assist regulators and policy makers in evaluating quality and consumer satisfaction and in determining necessary adaptations and improvements in the dynamic long-term care system.

(h) That long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in meeting the needs and preferences of long-term care consumers.

(i) That the state collects, analyzes, and distributes to the public on an ongoing basis complete data regarding current utilization of long-term care services and supports, unmet needs, consumer preferences, demographic data, workforce capacity, and other information that will assist the state in the continuing coordination and refinement of its long-term care system. In addition, ensure the state publishes periodic reports that assess the adequacy and efficacy of the reimbursement and enforcement systems and identify areas requiring improvement, unmet needs, successful innovations, and best practices.

(j) That state and the long-term care industry build and sustain an adequate, well-trained, highly motivated and appropriately compensated workforce across the long-term care continuum.

(k) That all stakeholders including consumers and their families and advocates, providers, representatives of the long-term care workforce, public officials and others have a continuing opportunity for meaningful input in the development and refinement of the long-term care system.

Sec. 4 [Long-Term Care Commission.]

(1) A commission on long-term care is hereby established, to be appointed by the governor.

(2) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in long-term care research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

(3) One representative each from the single point entry network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff from the Medical Services Administration and the Office of Services to the Aging shall serve as resources to the commission and shall assist the commission as needed.

(4) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting
member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 4(2).

(5) Commissioners are entitled to receive a stipend, if not otherwise compensated and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

(6) The governor shall designate one person from among the consumer membership to serve as chairperson of the commission, who shall serve at the pleasure of the governor.

(7) The commission shall do all of the following:

(a) Serve as an effective and visible advocate for all consumers of long-term care supports and services.

(b) Participate in the preparation and review, prior to the submission to the governor, of an ongoing, comprehensive statewide plan and budget for long-term care services and supports design, allocations and strategies to address and meet identified consumer preferences and needs.

(c) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (1)(b).

(d) Ensure broad, culturally competent, and effective public education initiatives are ongoing on long-term care issues, choices and opportunities for direct involvement by the public.

(e) Evaluate the performance of the designated single point of entry agencies on an annual basis and make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

(f) Continuously monitor spending and budget implementation, including how well expenditures match policy decisions and initiatives based on consumer preferences and needs.

(g) Meet at least six times per year.

(h) A quorum of the commission shall consist of at least fifty percent of the voting membership, provided at least eight consumer members are present or participating. Participation may be by telephone or other means, in accordance with other statutory provisions and as determined by the commission.

Sec. 5 [Long-Term Care Administration.]

(1) (Insert here language directing how the administration will be created, where it will be located, etc.).

(2) The long-term care administration shall do all of the following:

(a) Serve as an effective, visible, and accessible advocate for all consumers of long-term care supports and services.

(b) Prepare and implement an ongoing, comprehensive statewide plan for the governor for long-term care services and supports design, administration and oversight to ensure delivery of an organized system which meets identified consumer preferences and needs.

(c) Develop and implement an ongoing budget that ensures state financial resources follow consumer preferences under the comprehensive state plan for review by the commission prior to submission to the governor.
(d) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (2)(b).

(e) Recommend to the department director designations and de-designations of the state’s single points of entry (SPE) network agencies under established guidelines; recommend contract awards; establish performance and review standards for SPE agencies; receive standardized annual and other reporting from the agencies.

(f) Ensure broad, culturally competent and effective public education initiatives are ongoing on long-term care issues and choices.

(g) Advise the governor, the legislature, and directors of relevant agencies and department heads regarding changes in federal and state programs, statutes, and policies.

(j) As part of its ongoing planning, identify and address long-term care workforce capacity, training and regulatory issues in both the public and private sectors.

(k) Retain state approval over proposed changes in Medicaid policy and services related to long-term care before publication and comment; continually reform eligibility policy to improve timeliness and access.

(l) Develop and maintain a comprehensive state database and information collection system on long-term care service and supports capacities and utilization that is publicly accessible, while protecting individual consumer privacy, for the purposes of individual and state-aggregated planning, forecasting, and research.

(m) Ensure all necessary and vital linkages among acute, primary and chronic care management supports and services are maintained and continually strengthened to complement, leverage, and enhance services, supports and choices in the long-term care system.

(n) Develop and implement policies and procedures that will facilitate efficient and timely transition services for individuals moving from a nursing facility to home or apartment in the community. Services may include, but are not limited to payment of security deposits, moving expenses purchase of essential furnishings and durable medical equipment.

(o) Identify and implement progressive management models, culture change, and indicated administrative restructuring to maximize efficiency, optimize program design and services delivery; provide technical assistance in these areas to providers and interested members of the public.

(p) Establish a comprehensive, uniform, and enforceable consumer rights and appeals system.

Sec. 6 [Single Points of Entry.]

(1) It is the intent of the legislature that locally or regionally based single points of entry for long-term care serve as visible and effective access points for persons seeking long-term care and promote consumer education and choice of long-term care options.

(2) The director shall designate and maintain locally and regionally based single points of entry for long-term care that will serve as visible and effective access points for persons seeking long-term care and promote consumer choice.

(3) The department shall monitor designated single points of entry for long-term care to:

(a) prevent bias in eligibility determination and the promotion of specific services to the detriment of consumer choice and control;

(b) Review all consumer assessments and care plans to ensure consistency, quality and adherence to the principles of person-centered planning and other criteria established by the department;
(c) Assure the provision of quality assistance and supports;
(d) Assure that quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.
(e) Assure consumer access to an independent consumer advocate.

(4) The department shall establish and publicize a toll-free telephone number for those areas of the state in which a single point of entry is operational as a means of access to the single point of entry for consumers and others.

(5) The department shall promulgate rules establishing standards of reasonable promptness for the delivery of single point of entry services and for long-term care services and supports.

(6) The department shall require that designated single points of entry for long-term care perform the following duties and responsibilities:
   (a) Provide consumers and any others with information on and referral to any and all long-term care options, services, and supports;
   (b) Facilitate movement between supports, services, and settings in an adequate and timely manner that assures the safety and wellbeing of the consumer;
   (c) Assess a consumer’s eligibility for all Medicaid long-term care programs utilizing a comprehensive level of care tool;
   (d) Assist consumers to obtain a financial determination of eligibility for publicly funded long-term care programs;
   (e) Assist consumers to develop their long-term care support plans through a person-centered planning process;
   (f) Authorize and, if requested, arrange for needed transition services for consumers living in nursing facilities;
   (g) Work with consumers in acute and primary care settings as well as community settings to assure that they are presented with the full array of long-term care options;
   (h) Re-evaluate consumers’ need and eligibility for long-term care services on a regular basis;
   (i) Perform the authorization of Medicaid services identified in the consumer’s care supports plan.

(7) The department shall, in consultation with consumers, stakeholders, and members of the public, establish criteria for the designation of local or regional single points of entry for long-term care. The criteria shall assure that single points of entry for long-term care:
   (a) Are not a provider of direct Medicaid services. For purpose of this act, care management and supports coordination are not defined as a direct Medicaid service;
   (b) Are free from all legal and financial conflicts of interest with providers of Medicaid services;
   (c) Are capable of serving as the focal point for all persons seeking information about long-term care in their region, including those who will pay privately for services;
   (d) Are capable of performing consumer data collection, management, and reporting in compliance with state requirements;
   (e) Have quality assurance standards and procedures that measure consumer satisfaction, monitor consumer outcomes, and trigger care and supports plan changes;
   (f) Maintain internal and external appeals processes that provide for a review of individual decisions;
(g) Complete an initial evaluation of applicants for long-term care within two business days after contact by the individual or his or her legal representative; and

(h) In partnership with the consumer, develop a preliminary person-centered plan within seven days after the applicant is found eligible for services.

(8) Designated single points of access for long-term care that fail to meet the above criteria, and other fiscal and performance standards as determined by the department, may be subject to de-designation by the department.

(9) The department shall promulgate rules establishing timelines of within two business days or less for the completion of initial evaluations of individuals in urgent or emergent situations and shall by rule establish timelines for the completion of a final evaluation and assessment for all individuals, provided such timeline is not longer than two weeks from time of first contact.

(10) The department shall solicit proposals from entities seeking designation as a single point of entry and shall designate at least three agencies to serve as a single point of entry in at least three separate areas of the state. There shall be no more than one single point of entry in each designated region. The designated agencies shall serve in that capacity for an initial period of three years, subject to the provisions of Sec. 4(3).

(11) The department shall evaluate the performance of the designated agencies on an annual basis and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

(12) No later than October 1, 2008, the department shall have a designated agency to serve as a single point of entry in each region of the state. Nothing in this section shall be construed to prohibit the department from designating single points of entry throughout the entire state prior to said date.

(13) The department shall promulgate rules to implement this act within six months of enactment.

Sec. 7 [Quality.]

(1) The authority shall have a continuing responsibility to monitor state agencies’ performance in responding to, investigating, and ensuring appropriate outcomes to complaints and in performing its survey and enforcement functions. The Long-Term Care Administration shall issue regulations and policy bulletins, as appropriate, and take other appropriate action to improve performance or address serious deficiencies in state agencies’ practices with regard to handling complaints and in performing survey and enforcement functions.

(2) The authority shall establish a single toll free hotline to receive complaints from recipients of all Medicaid funded long-term care services and settings. State employees responsible for this function shall:

   (a) Staff the complaint line 24 hours a day, 7 days per week;
   (b) Be trained and certified in information and referral skills;
   (c) Conduct a brief intake;
   (d) Provide information and referral services to callers including information about relevant advocacy organizations; and
   (e) Route the call to the appropriate state agency or advocacy organization to record and respond to the consumer's concern. Relevant state agencies shall ensure on-call staff is available after hours to respond to any calls that are of an emergency nature. The authority
shall ensure that hotline staff are consistently informed how to contact on-call staff at all relevant state agencies to which long-term care complaints may be referred.

(3) The administration shall also ensure that consumers can file complaints about any Medicaid funded long-term care setting or service using a simple, web-based complaint form.

(4) The administration shall publicize the availability of the 24 hour hotline and web-based complaint system through appropriate public education efforts.

(5) The administration shall form a workgroup to determine if state agencies’ complaint protocols ensure a timely and complete response and to monitor for appropriate outcomes. The workgroup shall also address whether state agencies are performing their survey and enforcement functions in the most effective manner and if their practices promote quality and person-centered planning.

(a) The workgroup shall be comprised of a minimum of fifty percent consumers and/or consumer advocacy groups. The remainder of the workgroup shall include the State Long-Term Care Ombudsman and/or his/her representative, long-term care providers, a representative from the designated protection and advocacy system, and representatives from the departments that enforce the regulations in long-term care facilities.

(b) The workgroup will be charged with examining the number of consumer complaints received, the timeliness of response to these complaints, the process used by state investigators for these complaints, and the resolutions of these concerns. The workgroup will utilize existing resources such as Auditor General reports on state agencies that regulate long-term care facilities or services and any additional data it requires to perform its duties. Based on these findings, the workgroup will issue recommendations to the administration and to the director.

(c) The workgroup shall also be charged with a comprehensive review of state law and policy, including licensing laws and regulations, receivership provisions, and other mechanisms for regulating long-term care services to determine whether these laws and policies should be deleted, amended, or modified to promote quality, efficiency, and person-centered planning or to reflect changes in the long term care system. The workgroup shall issue recommendations to the authority and to the director.

(6) The departments responsible for licensing of long-term care settings shall, within twelve months of the date of enactment of this statute, promulgate rules to establish a process for identifying all licensed long-term care settings which, absent intervention by the state, are likely to either close or in which care is likely to diminish or remain below acceptable standards. In promulgating these rules, the departments shall consider, but not be limited to, the facility's financial stability, administrative capability, physical plant, and regulatory history.

(7) If a department has a reasonable suspicion that a licensed facility lacks administrative capability, financial stability, financial capability, or is not structurally sound, it shall have the right to request any and all relevant documentation including, but not limited to, independent audits of the facility, credit reports, physical plant inspections by appropriate professionals, and other relevant information. It may also investigate and consider factors such as whether the facility has filed for bankruptcy or whether foreclosure has been filed, consistently declining occupancy rates, chronic noncompliance, or other relevant information.

(8) In the event a department identifies a facility to be nonviable, it shall take appropriate measures to protect the health and safety of the residents, which may include the following:
The prompt appointment of a temporary manager or receiver with authority to take all actions necessary for the purpose of stabilizing the facility and protecting the residents, including:

1. Making all improvements necessary to ensure residents receive services that meet or exceed minimum regulatory standards; or
2. If necessary and appropriate, arranging for the safe and orderly transfer of residents out of the facility consistent with their person-centered plan and choices.

(b) Redistributing beds within the community to other facilities or making funding available in other long-term care settings, including home and community based care.

The State shall ensure that relevant state agencies have sufficient staff to meet all statutory or regulatory time frames for the completion of their responsibilities; effectively and expediently monitor services, supports, and facilities; respond to complaints; and enforce existing state laws and regulations regarding minimum standards for long-term care services, supports, and facilities.

Sec. 8 [Consumer Advocate.]

(1) No later than six months after the enactment of this act, the governor shall designate an agency with the independence and capacity to serve as an advocate for long-term care consumers, as set forth in this section. This designation shall continue indefinitely unless, for good cause shown, the agency is unwilling or incapable of performing its duties as set forth in this section.

(2) The designated agency shall have the responsibility to identify, investigate, and resolve complaints concerning services provided pursuant to this act; shall assist applicants for long-term care who have been denied services and supports; and shall pursue legal, administrative and other remedies at the individual and systemic level to ensure the protection of and advocacy for the rights of long-term care consumers.

(3) The designated agency shall have access at reasonable times to any consumer in a location in which services and supports are provided.

(4) The designated agency shall have access to the medical and mental health records of long-term care consumers or applicants for long-term care under any of the following conditions:

(a) With consent of the consumer or applicant or his or her legal representative;

(b) Without consent, if the consumer is unable to give consent and there is no legal representative or the state is the individual’s representative and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred; or

(c) Without consent, if the consumer is unable to give consent and the legal representative has refused or failed to act on behalf of the individual and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred.

(5) Records requested by the designated agency shall be made available for review and copying within three business days or, in the event of death or a request made pursuant to 4(b) or (c), within 24 hours.

(6) The designated agency shall maintain an office in each of the service areas of the single points of entry.

(7) The designated agency shall coordinate its activities with those of the state long-term care ombudsman and the designated protection and advocacy system.

(8) The designated agency shall prepare an annual report and provide information to the public and to policymakers regarding the problems of long-term care consumers.
(9) The legislature shall appropriate sufficient funds to enable the designated agency to perform its duties.

[A] Decision needs to be made on whether to name specific State officials, such as the Director of the Office of Services to the Aging and/or “up to three additional representatives of relevant State agencies.”

Comment:

NCSL lists this legislation on its Web page as a “model” Act pertaining to long-term care. CSG staff could not find the original Michigan bill on Michigan’s legislative Web page, or which, if any, states have enacted Michigan’s law or this “model.”

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
18-23A-01 Continuum of Care for the Elderly and Disabled (Rejected) IN

This Act requires the state office of the secretary of family and social services to develop a plan to ensure that services provided under programs administered by the office match the needs of the people receiving the services as closely as possible. It specifies certain topics that the plan must address. It requires the office to file a preliminary report with the legislative council not later than September 30, 2001, and a final report not later than June 30, 2002.

Submitted as:
Indiana
HB 1767 (enrolled version)

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act establishes a long-term care financing program and a long-term care benefits fund to hold the premiums and to pay benefits. The Act establishes a board of trustees to administer the program. The law sets up a temporary board of trustees to design the program, including the determination of the amount and means of collection of a tax, the nature and amount of benefits, recommending a third party administrator, and conducting research to ensure the financing scheme is not preempted by or in violation of the Health Insurance Portability and Accountability Act or the Employee Retirement Income and Security Act.

Submitted as:
Hawaii
HB 2638, H.D. 2, S.D. 1, C.D. 1
Status: Enacted into law in 2002.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
LEGISLATION

Supporting Families and Communities
This Act requires email service providers to give estate executors and administrators access to, or copies of, the decedent’s email account. The decedent must have been domiciled in Connecticut when they died, and estate executors and administrators must present proof of their status. Email service providers need not disclose information if doing so would violate federal law. Under the Act, an email service provider is an intermediary that gives end users the ability to send or receive email. An electronic mail account contains all email the end user sent or received that the provider has stored or recorded in its regular course of business. It also contains other stored or recorded electronic information directly related to the email services it provided, such as billing and payment information. Executors and administrators can satisfy the Act’s requirements by giving the service provider a written request, a copy of the death certificate, and a certified copy of their certificate of appointment. Alternatively, a probate judge who has jurisdiction over the estate can order disclosure.

Submitted as:
Connecticut
PA 05-136
Status: Enacted into law in 2005.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Concerning Access to Decedents' Electronic Mail Accounts.”

Section 2. [Definitions.]
(a) As used in this Act:
   (1) "Electronic mail service provider" means any person who is an intermediary in sending or receiving electronic mail, and provides to end users of electronic mail services the ability to send or receive electronic mail; and
   (2) "Electronic mail account" means all electronic mail sent or received by an end user of electronic mail services provided by an electronic mail service provider that is stored or recorded by such electronic mail service provider in the regular course of providing such services; and any other electronic information stored or recorded by such electronic mail service provider that is directly related to the electronic mail services provided to such end user by such electronic mail service provider, including, but not limited to, billing and payment information.

Section 3. [Access to Decedents’ Electronic Mail Accounts.]
(a) An electronic mail service provider shall provide, to the executor or administrator of the estate of a deceased person who was domiciled in this state at the time of his or her death, access to or copies of the contents of the electronic mail account of such deceased person upon receipt by the electronic mail service provider of:
(1) A written request for such access or copies made by such executor or administrator, accompanied by a copy of the death certificate and a certified copy of the certificate of appointment as executor or administrator; or

(2) an order of the court of probate that by law has jurisdiction of the estate of such deceased person.

(c) Nothing in this section shall be construed to require an electronic mail service provider to disclose any information in violation of any applicable federal law.

Section 4. [Severability.] [Insert severability clause.]

Section 5. [Repealer.] [Insert repealer clause.]

Section 6. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-17 Intergenerational Respite Care Assisted Living Facility Pilot Program (2007 SSL)

This Act creates a five-year intergenerational respite care assisted living facility pilot project for a not-for-profit facility. This facility will provide respite care for children and adults with disabilities and elderly adults with special needs who are currently cared for in their homes for a period of at least 24 hours a day and no more than 14 days.

Submitted as:
Florida
HB1559 (enrolled version)
Status: Enacted into law in 2005.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Relating to Intergenerational Respite Care.”

Section 2. [Legislative Intent: Intergenerational Respite Care Assisted Living.]
(1) It is the intent of the Legislature to establish a pilot program to:
   (a) Facilitate the receipt of in-home, family-based care by minors and adults with
disabilities and elderly persons with special needs through respite care for up to [14 days].
   (b) Prevent caregiver "burnout," in which the caregiver's health declines and he or
she is unable to continue to provide care so that the only option for the person with disabilities or
special needs is to receive institutional care.
   (c) Foster the development of intergenerational respite care assisted living
facilities to temporarily care for minors and adults with disabilities and elderly persons with
special needs in the same facility and to give caregivers the time they need for rejuvenation and
healing.

   (2) The Agency for Health Care Administration shall establish a [5-year] pilot program,
which shall license an intergenerational respite care assisted living facility that will provide
temporary personal, respite, and custodial care to minors and adults with disabilities and elderly
persons with special needs who do not require 24-hour nursing services. The intergenerational
respite care assisted living facility must:
   (a) Meet all applicable requirements and standards contained in [insert citation]
except that, for purposes of this section, the term “resident” means a person of any age
temporarily residing in and receiving care from the facility.
   (b) Provide respite care services for minors and adults with disabilities and elderly
persons with special needs for a period of at least 24 hours but not for more than [14 consecutive
days].
   (c) Provide a facility or facilities in which minors and adults reside in distinct and
separate living units.
   (d) Provide a facility that has a maximum of [48 beds] and is operated by a not-
for-profit entity.
(3) The agency may establish policies necessary to achieve the objectives specific to the pilot program and may adopt rules necessary to implement the program.

(4) After [4 years], the agency shall present its report on the effectiveness of the pilot program to the [President] of the recommendation as to whether the [Legislature] should make the program permanent.

Section 3. [Severability.] [Insert severability clause.]

Section 4. [Repealer.] [Insert repealer clause.]

Section 5. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act authorizes a Community Service Voice Mailbox Program that enables qualified low-income people to get an individually assigned telephone number and the ability to record a personal greeting and a secure private security code to retrieve messages. The community service voice mail service may include toll-free lines in community action agencies through which recipients can access their community service voice mailboxes at no charge. The Community Service Voice Mail Program is funded by a telephone assistance excise tax on all switched access lines and by funds from any federal government or other programs for the purpose.

Submitted as:
Washington
Chapter 134, Laws of 2003
Status: Enacted into law in 2003.

**Suggested State Legislation**

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as the "Community Service Voice Mail Program Act."

Section 2. [Definitions.] As used in this Act:

(1) "Community agency" means local community agencies that administer community service voice mail programs.

(2) "Community service voice mail" means a computerized voice mail system that provides low-income recipients with:

(a) An individually assigned telephone number;

(b) The ability to record a personal greeting; and

(c) A private security code to retrieve messages.

(3) "Department" means the [department of social and health services].

(4) "Service year" means the period between [July 1st and June 30th].

(5) "Community action agency" means local community action agencies or local community service agencies designated by the [department of community, trade, and economic development] under [insert citation].

Section 3. [Universal Telephone Service.] The [legislature] finds that universal telephone service is an important policy goal of the state. The [legislature] further finds that:

(1) Recent changes in the telecommunications industry, such as federal access charges, raise concerns about the ability of low-income people to continue to afford access to local exchange telephone service; and

(b) Many low-income people making the transition to independence from receiving supportive services through community agencies do not qualify for economic assistance from the [department].

(2) Therefore, the [legislature] finds that:
(a) It is in the public interest to take steps to mitigate the effects of these changes on low-income people; and

(b) Advances in telecommunications technologies, such as community service voice mail provide new and economically efficient ways to secure many of the benefits of universal service to low-income people who are not customers of local exchange telephone service.

Section 4. [Components of the Community Service Voice Mail Program.] The Community Service Voice Mail Program shall be available to participants of [department] programs set forth in [insert citation]. Assistance shall consist of the following components:

(1) A discount on service connection fees of [fifty percent or more] as set forth in [insert citation].

(2) A waiver of deposit requirements on local exchange service, as set forth in [insert citation].

(3) A discounted flat rate service for local exchange service, which shall be subject to the following conditions:

(a) The [commission] shall establish a single telephone assistance rate for all local exchange companies operating in this state. The telephone assistance rate shall include any federal end user access charges and any other charges necessary to obtain local exchange service.

(b) The [commission] shall, in establishing the telephone assistance rate, consider all charges for local exchange service, including federal end user access charges, mileage charges, extended area service, and any other charges necessary to obtain local exchange service.

(c) The telephone assistance rate shall only be available to eligible customers subscribing to the lowest available priced local exchange flat rate service, where the lowest priced local exchange flat rate service, including any federal end user access charges and any other charges necessary to obtain local exchange service, is greater than the telephone assistance rate. Low-income senior citizens [sixty years of age] and older and other low-income persons identified by the [department] as medically needy shall, where single-party service is available, be provided with single-party service as the lowest available local exchange flat rate service.

(d) The cost of providing the service shall be paid, to the maximum extent possible, by a waiver of all or part of the federal end user access charge(s) and, to the extent necessary, from the [Telephone Assistance Fund] created by [insert citation].

(4) A discount on a community service voice mailbox that provides recipients with

(a) An individually assigned telephone number;

(b) The ability to record a personal greeting; and

(c) A secure private security code to retrieve messages.

Section 5. [Funding the Community Service Voice Mail Program.]

(1) The Community Service Voice Mail Program shall be funded by a telephone assistance excise tax on all switched access lines and by funds from any federal government or other programs for this purpose. Switched access lines are defined in [insert citation]. The telephone assistance excise tax shall be applied equally to all residential and business access lines not to exceed [fourteen cents] per month. The telephone assistance excise tax shall be separately identified on each ratepayer's bill as the "Community Service Voice Mail Program."

All money collected from the telephone assistance excise tax shall be transferred to a [Telephone Assistance Fund] administered by the [department].
(2) Local exchange companies shall bill the [Fund] for their expenses incurred in offering the Community Service Voice Mail Program, including administrative and program expenses. The [department] shall disburse the money to the local exchange companies. The [department] is exempted from having to conclude a contract with local exchange companies in order to effect this reimbursement. The [department] shall recover its administrative costs from the [Fund]. The [department] may specify by rule the range and extent of administrative and program expenses that will be reimbursed to local exchange companies.

(3) The [department] shall enter into an agreement with the [department of community, trade, and economic development] for an amount not to exceed eight percent of the prior fiscal year's total revenue for the administrative and program expenses of providing community service voice mail services. The Community Service Voice Mail Service Program may include toll-free lines in community action agencies through which recipients can access their community service voice mailboxes at no charge.

Section 6. [Rules.]

(1) The [commission] and the [department] may adopt any rules necessary to implement [insert citation].

(2) Rules necessary for the implementation of community service voice mail services shall be made by the [commission] and the [department] in consultation with the [department of community, trade, and economic development].

Section 7. [Reimbursement Limits.] The [state] Telephone Assistance Program shall limit reimbursement to:

(1) One residential switched access line per eligible household, or

(2) One discounted community service voice mailbox per eligible person.

Section 8. [Waivers.] Local exchange companies shall waive deposits on local exchange service for eligible subscribers and provide a [fifty percent] discount on the company's customary charge for commencing telecommunications service for eligible subscribers. Part or all of the remaining [fifty percent] of service connection fees may be paid by funds from federal government or other programs for this purpose. The [commission] or other appropriate agency shall make timely application for any available federal funds. The remaining portion of the connection fee to be paid by the subscriber shall be expressly payable by installment fees spread over a period of months. A subscriber may, however, choose to pay the connection fee in a lump sum. Costs associated with the waiver and discount shall be accounted for separately and recovered from the telephone assistance fund.

Section 9. [Eligibility Requirements.]

(1) Adult recipients of [department]-administered programs for the financially needy which provide continuing financial or medical assistance, food stamps, or supportive services to persons in their own homes are eligible for participation in the Telephone Assistance Program. The [department] shall notify the participants of their eligibility.

(2) Participants in Community Service Voice Mail Programs are eligible for participation in services available under [insert citation] after completing use of community service voice mail services. Eligibility shall be for a period including the remainder of the current service year and the following service year. Community agencies shall notify the [department] of participants eligible under this subsection.
Section 10. [Reports.] The [department] shall report to the appropriate committees of the [legislature] by [December 1] of each year on the status of the state telephone assistance program. The report shall include the number of participants by qualifying social service programs receiving benefits from the telephone assistance program and the type of benefits participants receive. The report shall also include a description of the geographical distribution of participants, the program's annual revenue and expenditures, and any recommendations for legislative action.

Section 11. [Severability.] [Insert severability clause.]

Section 12. [Repealer.] [Insert repealer clause.]

Section 13. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
(    ) Include in 2008 Supplement
(    ) Reject

Comments/Note to staff:
26-28AS-19 Volunteer Advocates for Seniors (2005 SSL)

This Act permits a court to appoint a volunteer advocate for seniors to represent and protect for a limited period the interests of an incapacitated or protected person who is at least 55 years old. It requires volunteer advocates to report to the court and make recommendations about the incapacitated or protected people for whom they are advocating. This Act provides civil immunity for such volunteer advocates.

Submitted as:
Indiana
HEA 1178 (enrolled version)
Status: Enacted into law in 2004.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Concerning Volunteer Advocates for Seniors.”

Section 2. [Definitions.] As used in this Act:

(A) "Volunteer advocate for seniors" means an individual who:

(1) Is a volunteer;
(2) Has completed a limited guardian training program approved by a court;
(3) Is supervised by a community volunteer advocates for seniors program;
(4) Is appointed by a court to serve as a limited guardian for an incapacitated person or protected person who is at least [55 years] old; and
(5) Provides reports and makes recommendations to a court.

Section 3. [Appointing a Volunteer Advocate for Seniors.]

(A) A court in a proceeding under this Act may appoint a volunteer advocate for seniors. A volunteer advocate for seniors shall submit to the court:

(1) A progress report [15 days] after the date of appointment describing the matters required by the court; and
(2) A final report [60 days] after the date of appointment:

(a) Describing the matters required by the court; and
(b) Making recommendations to the court as to whether a need exists for continued representation to the court as to whether a need exists for continued representation of the incapacitated or protected person.

(B) The court may appoint an attorney to represent a volunteer advocate for seniors.

Section 4. [Duties of Volunteer Advocates for Seniors.]

(A) A volunteer advocate for seniors shall:

(1) Serve as a limited guardian to represent and protect the interests of an incapacitated or protected person who is at least [55 years] old;
(2) Investigate and gather information regarding the health, welfare and financial
circumstances of the incapacitated or protected person, as directed by a court;

(3) Facilitate and authorize health care, social welfare, and residential placement services as needed by the incapacitated or protected person;

(4) Advocate for the rights of the incapacitated or protected person;

(5) Facilitate legal representation for the incapacitated or protected person; and

(6) Perform any other duty required by a court.

(B) A volunteer advocate for seniors may:

(1) Consent to medical and other professional care and treatment for the incapacitated or protected person's health and welfare;

(2) Secure the appointment of a guardian or co-guardian in another state;

(3) Take custody of the incapacitated or protected person and establish the person's place of abode within this or another state in accordance with [insert citation];

(4) Institute proceedings or take other appropriate action to compel the performance by any person of a duty to support the incapacitated or protected person's health or welfare; and

(5) Delegate to the incapacitated or protected person certain responsibilities for decisions affecting the person's business affairs and well-being.

Section 5. [Length of Service of Court-Appointed Volunteer Advocate for Seniors.] If a court appoints an individual to serve as a volunteer advocate for seniors, the appointment shall be for a period of [60 days]. After the initial [60 day] period, the court may, upon petition by the volunteer or upon the court's own motion, extend the appointment for a period as determined by the court to be necessary to protect the interests of the incapacitated or protected person.

Section 6. [Volunteer Advocate for Seniors as Officer of the Court.] A volunteer advocate for seniors is considered an officer of the court for the purpose of representing the interests of an incapacitated or protected person.

Section 7. [Volunteer Advocate for Seniors' Immunity for Civil Liability.] Except for gross misconduct:

(1) A volunteer advocate for seniors program that;

(2) An employee of a volunteer advocates for seniors program who; or

(3) A volunteer for a volunteer advocates for seniors program who performs duties in good faith is immune from any civil liability resulting from the program's, employee's, or volunteer's performance.

Section 8. [Consent to Refuse Health Care.] A volunteer advocate for seniors is not authorized to consent to or refuse health care as defined in [insert citation] for an individual if:

(1) A spouse, a parent, an adult child, or an adult sibling of the individual or the individual's religious superior, if the individual is a member of a religious order, is available, capable, and suitable to consent to or refuse the health care on behalf of the individual; or

(2) The individual has previously:

(A) Appointed a health care representative under [insert citation];

(B) Authorized health care under [insert citation];

(C) Executed a power of attorney under [insert citation]; or

(D) Had a guardian appointed by the court under [insert citation].
Section 9. [Changing the Physical Presence of a Protected Person.] A guardian (other than a temporary guardian) or volunteer advocate for seniors appointed under [insert citation] may, with the approval of and under such conditions as may be imposed by the court after notice and hearing, change the physical presence of the protected person to another place in this state or to another state if the court finds that such a change is in the best interests of the protected person. Upon such a change, the guardianship may be limited or terminated by the court.

Section 10. [Severability.] [Insert severability clause.]

Section 11. [Repealer.] [Insert repealer clause.]

Section 12. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff:
Imagine losing ownership of your home at the end of your life because of questionable business practices and terms that you don’t fully understand, but were persuaded to agree to. Imagine being plunged into significant debt for the same reason. Such is the case in America as companies target the poor and elderly for high-interest and high-fee loans and mortgages.

According to the Association for Community Reform Now (ACORN), predatory lending generally involves:

- Aggressive and deceptive marketing;
- Attaching prepayment penalties to a loan, and typically at high rates;
- Balloon payments;
- Charging higher interest rates than a borrower’s credit warrants;
- Financing excessive fees into loans;
- Home improvement scams;
- Loan flipping;
- Making loans for more than 100% loan to value;
- Making loans without regard to the borrower’s ability to pay;
- Negative amortization;
- Property flipping; and
- Single premium credit insurance.

Several states introduced or enacted legislation in 2001 and 2002 to combat the problem.

**Alabama**

Senate Bill 273 of 2002 would prohibit making equity-based loans that include financing high points and financial fees.

**California**

AB 489, which became law in 2001, imposes various requirements on consumer loans secured by specified real property, defined as “covered loans.” The law prohibits various acts in making covered loans, including the following:

- Failing to consider the financial ability of a borrower to repay the loan;
- Financing specific types of credit insurance into a consumer loan transaction;
- Making a covered loan without providing the consumer a specified disclosure, and
- Recommending or encouraging a consumer to default on an existing consumer loan in order to solicit or make a covered loan that refinances the consumer loan.

Violations are subject to a civil penalty.

**Colorado**
Colorado, HB 1259, which became law in 2002, creates additional protections regarding certain “covered loans” as defined in the federal “Home Ownership and Equity Protection Act of 1994,” including:

- Charging a fee for providing a credit balance;
- Financing of credit insurance;
- Increased interest rates after default;
- Lending without regard to repayment ability;
- Limitations on balloon payments, accelerations of indebtedness;
- Mandatory arbitration clauses;
- Negative amortization;
- Prepayment penalties;
- Prohibiting advance payments;
- Recommendations to default on existing loans;
- Refinancing that does not benefit the borrower or that results in a loss of certain benefits to the borrower.
- Requiring certain disclosures and reporting; and
- Using loan proceeds to pay home improvement contractors.

This measure also preempts local law attempting to regulate lending activities that are subject to the Act or to certain federal authorities; specifies civil remedies; and grants the state attorney general authority to enforce the consumer protections.

Colorado Chapter 145 of 2001 requires the owners of certain loans secured by deeds of trust that encumber dwellings, and owners of loans primarily secured by an interest in land, to comply with the notice provisions of the “Uniform Consumer Credit Code” before the commencement of foreclosure proceedings. Failure of any owner to comply with such provisions necessarily precludes said people from providing default information to a credit-reporting agency; and constitutes an absolute defense in any debt recovery action. It also clarifies the definition of “consumer loan.”

**Connecticut**

Public Act 01-34 of 2001 requires lenders to make certain disclosures to prospective borrowers seeking high-cost home loans, including the interest rate and the consequences of mortgaging a home. It prohibits lenders from including certain loan provisions or from taking certain actions with respect to high-cost home loans, such as charging unwarranted or excessive fees or providing incomplete information. It also imposes conditions on a lender's ability to sell credit insurance to a borrower.

The Act allows lenders to charge a fee for payoff statements only when they are delivered on an expedited basis pursuant to an agreement with the borrower. It creates new penalties for lenders who violate its provisions.

**Florida**

Concerning high-cost home loans, Chapter 57 of 2002:

- Allows a borrower to cure a default;
• Authorizes the state banking department to bring actions for injunctions; providing for issuance of subpoenas;
• Authorizes the state banking department to impose certain fines under certain circumstances;
• Authorizes the state banking department to issue and serve cease and desist orders for certain purposes;
  • Prohibits certain acts relating to high-cost home loans;
  • Provides that a lender who violates the Act forfeits the interest in the high-cost home loan;
• Provides that certain unintentional good-faith errors are not deemed violations of the Act;
• Requires certain disclosures for high-cost home loans;
• Requires lenders of high-cost home loans to provide notice to borrowers prior to taking foreclosure actions, and
• Specifies the liability of purchasers and assignees.

Georgia

SB 435 of 2002 would:
• Create a Council for the Prevention of Predatory Lending through Education;
• Direct the Council to design, approve, and implement education programs that inform and educate consumers, particularly those most vulnerable to being taken advantage of by predatory and unscrupulous lenders, as to the dangers and pitfalls of entering into a home loan through cooperation contracting with community based organizations to accomplish such directive;
• Direct the Council to refer individual cases in which there is evidence of an apparent violation of federal or state laws or regulations to the appropriate governmental agency for further investigation and action, and
• Direct the Council to conduct an extensive statewide study of the root cause of home loans that go into default and foreclosure, using as much empirical data as are available.

Georgia HB 1361:
• Creates specific and numerous consumer protections for covered home loans and high-cost home loans, and
• Prohibits practices and limitations relating to covered home loans and high-cost home loans;
• Provides for penalties and enforcement; to provide for exceptions for unintentional violations.
  This bill became law in 2002.

Iowa

HCR 21 of 2002 would establish a legislative committee to study predatory and sub prime lending practices.
Massachusetts

Senate Bill 18 of 2002 would establish practices to govern high-cost home loans. Such loans are defined as loans in which the annual percentage rate of the home at consummation exceeds five or more percentage points the average weekly yield on United States Treasury securities adjusted to a constant maturity of one year.

New York

A11856, which became law in 2001, imposes certain requirements on high-cost home loans. These include:

- Requiring all high-cost home loans to have a legend on the top of the mortgage indicating that it is a high-cost home loan;
- Applying to any person who acting in bad faith attempts to avoid said provisions by splitting or dividing a high cost-home loan transaction;
- Providing that a lender acting in good faith that fails to comply with certain parts of the Act would not be deemed in violation of the section if the lender notifies the borrower of the compliance failure within 30 days of the loan closing and appropriate restitution is made or the compliance failure resulted from a bona fide error;
- Allowing for a private right of action against a lender or mortgage broker within 6 years of the origination of the loan;
- Directing that violators of the Act are liable to the borrowers for actual damages and statutory damages;
- Allowing a court to award reasonable attorney fees to a borrower;
- Providing for injunctive, declaratory and other equitable relief for borrowers;
- Deeming a home loan agreement void if intentional violation by the lender of the Act is found by a court;
- Allowing a borrower to recover any payments certain circumstances;
- Granting borrowers the right to rescind upon a judicial finding that the high-cost home loan violates provisions of the Act whether such violation is raised as an affirmative claim or defense, and
- Granting borrowers the right to assert any claims in recoupment and defenses to payment in a foreclosure action against the assignee or original lender of the loan.

North Carolina

Session Law 332 of 1999 modifies permissible fees which may be charged in connection with home loans secured by first mortgage or first deed of trust, to impose restrictions and limitations on high-cost home loans, to revise the permissible fees and charges on certain loans, to prohibit unfair or deceptive practices by mortgage brokers and lenders, and to provide for public education and counseling about predatory lending.

Pennsylvania

Act 55 of 2001 regulates the terms and conditions of certain sub prime mortgage loan transactions. Generally, it prohibits business entities and affiliates from making, issuing or
arranging sub-prime or high-cost loans or assisting others in so doing in an abusive, unscrupulous or misleading manner. The law also provides for enforcement, a private right of action, education, outreach, and counseling about such transactions.

**Virginia**

Chapter 511 of 2001 increases the maximum penalty for a violation of the state Mortgage Lender and Broker Act from $1,000 to $2,500, and increases the amount of a bond that mortgage lenders and brokers are required to post from $5,000 to $25,000. The measure also prohibits a mortgage lender from recommending or encouraging a person to default on an existing loan or other debt, if such default adversely affects such person's creditworthiness, in connection with the solicitation or making of a refinancing mortgage loan.

Chapter 510 of 2001 prohibits mortgage lenders and brokers from flipping mortgage loans. "Flipping" a mortgage loan means refinancing a mortgage loan within 12 months after the mortgage was originated when refinancing doesn’t benefit the borrower.

**Disposition:**

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-21 Assisted Living Communities (2002 SSL)

This Act:
- Requires certification of assisted living communities by the state of aging services;
- Defines “activities of daily living”, “assistance with self-administration of medication,” “assisted living community,” “client,” “danger,” “health services,” “instrumental activities of daily living,” “living unit,” and “mobile non-ambulatory;”
- Establishes physical requirements of the community and required services;
- Permits clients to contract or arrange for additional services to be provided by people outside the assisted living community, if permitted by the community’s policies;
- Requires an assisted living community to inform clients regarding policies relating to contracting or arranging for additional services upon entering into a lease agreement;
- Requires communities to help residents find appropriate living arrangements upon a move-out notice and to share information on alternative living arrangements provided by the state office of aging services;
- Prohibits any business from operating or marketing its services as an assisted living community without having a current application for certification on file or receiving certification;
- Requires the office of aging services to determine the feasibility of recognizing accreditation by other organizations in lieu of certification;
- Requires the state cabinet for health services to promulgate an administrative regulation to establish procedures related to applying for, reviewing, approving, denying, or revoking certification, as well as to the conduct of hearings upon appeals;
- Requires an initial and annual certification review with an on-site visit;
- Requires personnel that conduct certification reviews to have the skills, training, experience, and ongoing education to perform certification reviews;
- Authorizes the cabinet to assess a certification review fee of twenty dollars per living unit that in the aggregate is no less than three hundred dollars and no more than one thousand six hundred dollars;
- Requires the office of aging services to submit a yearly breakdown of fees assessed and costs incurred for conducting reviews;
- Authorizes the office to request any additional information or conduct additional on-site visits;
- Requires the office of aging services to report any alleged or actual cases of health services being delivered by the staff of an assisted living community;
- Requires staff to report abuse, neglect, or exploitation;
- Identifies client criteria;
- Establishes the content required in the lease agreement and disclosure;
- Requires grievance policies to address confidentiality of complaints and the process for resolving grievances;
- Requires an assisted living community to provide consumer education materials to the public or refer the request for information to the office of aging services;
- Establishes staffing requirements;
- Establishes orientation and in-service education requirements for employees;
Exempts assisted living communities open or under construction on or before the effective date of this Act from the requirement that each living unit be at least two hundred square feet and have a bathtub or shower;

Establishes penalties for operating or marketing as an assisted living community without having a current application on file or being certified;

Exempts religious orders from certification requirements;

Prohibits businesses that do not provide assistance with activities of daily living or assistance with self-administration of medications from certification;

Requires the office to provide written correspondence to any lender, upon request, to denote whether the architectural drawings and lease agreement conditionally met certification requirements; permits the office to charge a fee of no more than two hundred fifty dollars for the written correspondence to the lender, and

Requires a criminal record check for initial employment in an assisted living facility.

Submitted as:
Kentucky
HB 148
Status: Enacted into law in 2000.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Relating To Assisted Living Communities.”

Section 2. [Definitions.] As used in this Act:

(1) “Activities of daily living” means normal daily activities, including bathing, dressing, grooming, transferring, toileting, and eating;

(2) “Assistance with self-administration of medication” means:
(a) Reminding the client to take medications;
(b) Reading the medication’s label;
(c) Confirming that medication is being taken by the client for whom it is prescribed;
(d) Opening the dosage packaging or medication container, but not removing or handling the actual medication;
(e) Storing the medication in a manner that is accessible to the client; and
(f) Making available the means of communicating with the client’s physician and pharmacy for prescriptions by telephone, facsimile, or other electronic device.

(3) “Assisted living community” means a series of living units on the same site, operated as [one (1)] business entity, and certified under Section 5 of this Act to provide services for [five (5)] or more adult people not related within the third degree of consanguinity to the owner or manager;

(4) “Client” means an adult person who has entered into a lease agreement with an assisted living community;
(5) “Crime” means a conviction of or a plea of guilty to a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or the commission of a sex crime. Conviction of or a plea of guilty to an offense committed outside this state is a crime if the offense would have been a felony in this state if committed in this state.

(6) “Danger” means physical harm or threat of physical harm to one’s self or others;

(7) “Direct service” means personal or group interaction between the employee and the nursing facility resident or the senior citizen;

(8) “Health services” has the same meaning as in [insert citation];

(9) “Instrumental activities of daily living” means activities to support independent living including, but not limited to, housekeeping, shopping, laundry, chores, transportation, and clerical assistance;

(10) “Living unit” means a portion of an assisted living community occupied as the living quarters of a client under a lease agreement;

(11) “Mobile non-ambulatory” means unable to walk without assistance, but able to move from place to place with the use of a device including, but not limited to, a walker, crutches, or wheelchair;

(12) “Nursing pool” means any person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in nursing facilities for medical personnel including, but not limited to, nurses, nursing assistants, nurses’ aides, and orderlies;

(13) “Office” means the [office of aging services]; and

(14) “Senior citizen” means a person [sixty (60)] years of age or older.

Section 3. [Assisted Living Units.]

(1) Each living unit in an assisted living community shall:

(a) Be at least [two hundred (200)] square feet for single occupancy, or for double occupancy if the room is shared with a spouse or another individual by mutual agreement;

(b) Include at least [one (1)] unfurnished room with a lockable door, private bathroom with a tub or shower, provisions for emergency response, window to the outdoors, and a telephone jack;

(c) Have an individual thermostat control if the assisted living community has more than [twenty (20)] units; and

(d) Have temperatures that are not under a client’s direct control at a minimum of [seventy-one (71)] degrees Fahrenheit in winter conditions and a maximum of [eighty-one (81) degrees] Fahrenheit in summer conditions if the assisted living community has [twenty (20)] or fewer units.

(2) Each client shall be provided access to central dining, a laundry facility, and a central living room.

(3) Each assisted living community shall comply with applicable building and life safety codes.

Section 4. [Assisted Living Communities – Services.]

(1) The assisted living community shall provide each client with the following services according to the lease agreement:

(a) Assistance with activities of daily living and instrumental activities of daily living;
(b) Three (3) meals and snacks made available each day;
(c) Scheduled daily social activities that address the general preferences of clients; and
(d) Assistance with self-administration of medication.

(2) Clients of an assisted living community may arrange for additional services under direct contract or arrangement with an outside agent, professional, provider, or other individual designated by the client if permitted by the policies of the assisted living community.

(3) Upon entering into a lease agreement, an assisted living community shall inform the client in writing about policies relating to the contracting or arranging for additional services.

(4) Each assisted living community shall assist each client upon a move-out notice to find appropriate living arrangements. Each assisted living community shall share information provided from the [office] regarding options for alternative living arrangements at the time a move-out notice is given to the client.

Section 5. [Certification Review Process For Assisted Living Communities.]

(1) The [cabinet for health services] shall establish by the promulgation of administrative regulation under [insert citation], an initial and annual certification review process for assisted living communities that shall include an on-site visit. This administrative regulation shall establish procedures related to applying for, reviewing, and approving, denying, or revoking certification, as well as the conduct of hearings upon appeals as governed under [insert citation].

(2) No assisted living community shall operate unless its owner or manager has:

(a) Filed a current application for the assisted living community to be certified by the [office]; or
(b) Received certification of the assisted living community from the [office].

(3) No business shall market its services as an assisted living community unless its owner or manager has:

(a) Filed a current application for the assisted living community to be certified by the [office]; or
(b) Received certification of the assisted living community from the [office].

(4) The [office] shall determine the feasibility of recognizing accreditation by other organizations in lieu of certification from the [office].

(5) Individuals designated by the [office] to conduct certification reviews shall have the skills, training, experience, and ongoing education to perform certification reviews.

(6) Upon conducting a certification review, the [office] shall assess an assisted living community certification fee in the amount of [twenty (20)] dollars per living unit that in the aggregate for each assisted living community is no less than [three hundred (300)] dollars and no more than [one thousand six hundred (1,600)] dollars. The [office] shall submit to the [legislative research commission], by [June 30] of each year, a breakdown of fees assessed and costs incurred for conducting certification reviews.

(7) Notwithstanding any provision of law to the contrary, the [office] may request any additional information from an assisted living community or conduct additional on-site visits to ensure compliance with the provisions of Sections 1 to 16 of this Act.

Section 6. [Reporting and Record Keeping.]

(1) The [office] shall report to the [division of licensing and regulation] any alleged or actual cases of health services being delivered by the staff of an assisted living community.
(2) An assisted living community shall have written policies on reporting and record keeping of alleged or actual cases of abuse, neglect, or exploitation of an adult.

(3) Any assisted living community staff member who has reasonable cause to suspect that a client has suffered abuse, neglect, or exploitation shall report the abuse, neglect, or exploitation.

Section 7. [Client Criteria.]
A client shall meet the following criteria:
(1) Be ambulatory or mobile non-ambulatory, unless due to a temporary health condition for which health services are being provided in accordance with subsections (2) and (3) of Section 4 of this Act; and
(2) Not be a danger.

Section 8. [Lease Agreements.]
A lease agreement, in no smaller type than twelve (12) point font, shall be executed by the client and the assisted living community and shall include:
(1) Client data, for the purpose of providing service, to include:
   (a) A functional needs assessment pertaining to the client’s ability to perform activities of daily living and instrumental activities of daily living;
   (b) Emergency contact person’s name;
   (c) Name of responsible party or legal guardian, if applicable;
   (d) Attending physician’s name;
   (e) Information regarding personal preferences and social factors;
   (f) Advance directive under [insert citation], if desired by the client; and
   (g) Optional information helpful to identify services that meet the client’s needs.
(2) Assisted living community’s policy regarding termination of the lease agreement;
(3) Terms of occupancy;
(4) General services and fee structure;
(5) Information regarding specific services provided, description of the living unit, and associated fees;
(6) Provisions for modifying client services and fees;
(7) Minimum [thirty (30)] day notice provision for a change in the community’s fee structure;
(8) Minimum [thirty (30)] day move-out notice provision for client nonpayment, subject to applicable landlord or tenant laws;
(9) Provisions for assisting any client that has received a move-out notice to find appropriate living arrangements prior to the actual move-out date;
(10) Refund and cancellation policies;
(11) Description of any special programming, staffing, or training if an assisted living community is marketed as providing special programming, staffing, or training on behalf of clients with particular needs or conditions;
(12) Other community rights, policies, practices, and procedures;
(13) Other client rights and responsibilities, including compliance with subsections (2) and (3) of Section 4 of this Act; and
(14) Grievance policies that minimally address issues related to confidentiality of complaints and the process for resolving grievances between the client and the assisted living community.

Section 9. [Consumer Information.]

(1) An assisted living community shall provide any interested person with a:
   (a) Consumer publication, as approved by the [office], that contains a thorough description of state laws and regulations governing assisted living communities;
   (b) Standard consumer checklist provided by the [office]; and
   (c) Description of any special programming, staffing, or training if the assisted living community markets itself as providing special programming, staffing, or training on behalf of clients with particular needs or conditions.

(2) An assisted living community may refer a request for information required in subsection (1)(a) of this Section to the [office].

Section 10. [Staffing Requirements: Assisted Living Communities.]

(1) Staffing in an assisted living community shall be sufficient in number and qualification to meet the [twenty-four (24)] hour scheduled and unscheduled needs of its clients and the services provided.

(2) [One (1)] awake staff member shall be on site at all times.

(3) An assisted living community shall have a designated manager who is at least [twenty-one (21)] years of age, has at least a high school diploma or a General Educational Development diploma, and has demonstrated management or administrative ability to maintain the daily operations.

(4) No employee who has an active communicable disease reportable to the [department for public health] shall be permitted to work in an assisted living community if the employee is a danger to the clients or other employees.

Section 11. [Staff Orientation and In-Service Education.]

Assisted living community staff and management shall receive orientation and in-service education on the following topics as applicable to the employee’s assigned duties:

(1) Client rights;
(2) Community policies;
(3) Adult first aid;
(4) Cardiopulmonary resuscitation;
(5) Adult abuse and neglect;
(6) Alzheimer’s disease and other types of dementia;
(7) Emergency procedures;
(8) Aging process;
(9) Assistance with activities of daily living and instrumental activities of daily living;
(10) Particular needs or conditions if the assisted living community markets itself as providing special programming, staffing, or training on behalf of clients with particular needs or conditions; and
(11) Assistance with self-administration of medication.

Section 12. [Exemptions.]
(1) Any assisted living community that was open or under construction on or before the effective date of this Act shall be exempt from the requirement that each living unit have a bathtub or shower.

(2) Any assisted living community that was open or under construction on or before the effective date of this Act shall have a minimum of [one (1)] bathtub or shower for each [five (5)] clients.

(3) Any assisted living community that was open or under construction on or before the effective date of this Act shall be exempt from the requirement that each living unit shall be at least [two hundred (200)] square feet for single occupancy, or for double occupancy if the room is shared with a spouse or another individual by mutual agreement.

Section 13. [Applications and Certification: Penalties for Not Complying.]

(1) Any assisted living community that provides services without filing a current application with the [office] or receiving certification by the [office] may be fined up to [five hundred (500)] dollars per day.

(2) Any business that markets its services as an assisted living community without filing a current application with the [office] or receiving certification by the [office] may be fined up to [five hundred (500)] dollars per day.

Section 14. [Religious Orders.] Religious orders providing assistance with activities of daily living, instrumental activities of daily living, and self-administration of medication to vowed members residing in the order’s retirement housing shall not be required to comply with the provisions of Sections 1 to 16 of this Act.

Section 15. [Certification: Exceptions.] Any business, not licensed or certified in another capacity, that complies with some provisions of Sections 1 to 16 of this Act but does not provide assistance with any activities of daily living or assistance with self-administration of medication shall not be eligible for certification as an assisted living community under Sections 1 to 16 of this Act.

Section 16. [Architectural Drawings and Lease Agreements: Correspondence Noting Compliance with this Act.] If a person or business seeks financing for an assisted living community project, the [office] shall provide written correspondence to the lender, upon request, to denote whether the architectural drawings and lease agreement conditionally comply with the provisions of Sections 1 to 16 of this Act. The [office] may charge a fee of no more than [two hundred fifty (250)] dollars or the written correspondence to the lender.

Section 17. [Prohibiting Using Convicted Felons as Employees.] (1) No long-term care facility as defined by [insert citation] or nursing pool providing staff to a nursing facility, or assisted living community shall knowingly employ a person in a position which involves providing direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

(2) A nursing facility or nursing pool providing staff to a nursing facility, or assisted living community may employ people convicted of or pleading guilty to an offense classified as a misdemeanor if the crime is not related to abuse, neglect, or exploitation of an adult.
(3) Each long-term care facility as defined by [insert citation], or nursing pool providing staff to a nursing facility, or assisted living community shall request all conviction information from the [justice cabinet] for any applicant for employment.

(4) The long-term care facility or nursing pool providing staff to a nursing facility, or assisted living community may temporarily employ an applicant pending the receipt of the conviction information.

Section 18. [Employment Application Forms: Specifications]

(1) Each application form provided by the employer, or each application form provided by a facility either contracted or operated by the [department for mental health and mental retardation services] of the [cabinet for health services], to the applicant for initial employment in an assisted living community, nursing facility, or nursing pool providing staff to a nursing facility, or in a position funded by the [department for social services] or the [office of aging services] of the [cabinet for families and children] and which involves providing direct services to senior citizens shall conspicuously state the following:

“For this type of employment, state law requires a criminal record check as a condition of employment.”

(2) Any request for criminal records of an applicant as provided under subsection (1) of this section shall be on a form or through a process approved by the [justice cabinet]. The [justice cabinet] may charge a fee to be paid by the applicant or state agency in an amount no greater than the actual cost of processing the request and shall not exceed [five (5)] dollars per application.

Section 19. [Severability.] [Insert severability clause.]

Section 20. [Repealer.] [Insert repealer clause.]

Section 21. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
Putting a family member in a nursing home can be upsetting – ask anyone who has done it. Ensuring that a family member receives good care while in the home can also be a concern. Enabling the family to electronically monitor their loved one in the home has been proposed as a way to help accomplish the latter.

In 2001, legislation was introduced in nine states to address electronic monitoring of nursing home patients by their relatives or legal guardian: Florida, Louisiana, Maryland, Massachusetts, North Carolina, New Jersey, Ohio, Pennsylvania and Texas. Only Florida and Texas enacted laws, but the others are worth mentioning as the issue is likely to recur in other state capitals in 2002 and beyond.

Florida enacted a provision in 2001 in an omnibus long-term care reform Act (SB 1202) that requires the state agency for health care administration and the state office of the attorney general to study the use of electronic monitoring devices in nursing homes.

Louisiana’s House adopted HSR 26 which requests the House Health and Welfare Committee to study the use of electronic monitoring devices to allow a nursing home resident or the resident’s legal representative to monitor the resident. HB 457, which permits a nursing home resident or the resident’s legal representative to monitor the resident through the use of electronic monitoring devices, was scheduled for a hearing in January 2002.

Maryland HB 433 requires nursing homes to permit a resident or a resident’s legal representative to monitor the resident with video cameras or other electronic monitoring devices. It requires the homes to provide power sources and mounting space to set up electronic monitoring devices. It prohibits the homes from refusing to admit an individual or removing a resident from the related institution because of a request to install an electronic monitoring device. The bill establishes penalties for violators and requires that tapes created from electronic monitoring be admissible in criminal and civil actions brought in state courts. This bill did not pass the Legislature in 2001. It was referred for interim study in 2001. It must be reintroduced in the next Legislature to remain viable. Maryland legislative staff said this legislation will not likely be introduced again in Maryland until after 2003. That will be after a report is due on a pilot program that was started in 2001 to set up monitors in three nursing homes that volunteered for the pilot.

New Jersey SB 2231 directs that a nursing home shall permit a resident to be monitored or the resident’s legal representative to monitor the resident in the resident’s room through the use of an electronic monitoring device in accordance with the provisions of the Act. A nursing home shall inform a resident and the resident’s legal representative of the resident’s right to electronic monitoring. New Jersey SB 2231 was in committee as of July 27, 2001.

North Carolina HB 996 permits residents of nursing homes or adult care homes, and their families to monitor the resident through the use of video cameras or other electronic monitoring devices at the expense of the resident; requires nursing homes and adult care homes to provide a power source and mounting space for electronic monitoring devices; prohibits nursing homes and adult care homes from refusing to admit residents because of a request to install electronic monitoring devices; and requires that tapes from monitoring devices be admissible in criminal and civil actions subject to the rules of evidence. HB 996 died in committee.

Ohio law currently specifies rights of a resident of a home, including the right to a safe and clean living environment, the right to make personal decisions, and the right to be free from abuse. “Home” includes facilities licensed by the Director of Health as nursing homes or
residential care facilities; skilled nursing facilities certified under Medicare or Medicaid; and county homes. A resident who believes that the resident’s rights have been violated may file a grievance with the home’s grievance committee. Any other person may file a report with the Ohio Department of Health. If the grievance committee determines that a violation exists, the violation must be corrected within ten days. If the violation is not corrected, the grievance committee must refer the violation to the Department of Health. The Department of Health must investigate grievances or refer them to the attorney general for investigation. It also must investigate any reports it receives from people who are not residents of homes. Under certain circumstances the Department may hold adjudicative hearings. If a home is found to have violated a resident’s rights, it may be ordered to correct the violation and fined. The home may appeal the Department’s order to a court of common pleas. The Department must refer any criminal matters to the county prosecuting attorney.

Ohio HB 216 extends residents’ rights to include the right, on request, to the use of electronic monitoring devices in a resident’s room. To exercise this right, a resident or resident’s sponsor must pay the costs of the devices and installation; arrange the device so as to protect the privacy of others to the extent reasonably possible; and have a notice of electronic monitoring posted on the resident’s room door.

Under the bill, “electronic monitoring device” means video surveillance cameras, audio devices, video telephones, Internet video surveillance devices, or any other device designed to capture the audio recordings or visual images of its surroundings.

Under Ohio’s bill, a home must allow a resident to use an electronic monitoring device and provide reasonable physical accommodations for the device, including a secure place to mount the device and access to a power source. A home may not refuse to admit an individual as a resident and may not discharge a resident due to a request to use an electronic monitoring device. The home’s administrator may require requests for installation of electronic monitoring devices to be made in writing. If a home fails to honor a resident’s right to use electronic monitoring devices, the resident has the same recourse as provided in current law when other resident’s rights are violated: the resident may file a grievance with the home’s grievance committee, which is required to refer it to the Department of Health if a violation is found and is not corrected. Ohio HB 216 was in committee as of August 24, 2001.

This SSL draft is based on Texas SB 177, an Act that permits audio or video monitoring of a resident’s room in a nursing home facility and provides the parameters for both the resident and the nursing home to follow in relation to monitoring.

Submitted as:
Texas
SB 177 (enrolled version)

Suggested State Legislation

(Title, enacting clause, etc.)

1 Section 1. [Short Title.] This Act may cited as “An Act Relating to Electronic Monitoring Devices in the Rooms of Residents of Convalescent or Nursing Homes or Related Institutions.”

2 Section 2. [Definitions.] As used in this Act:
(a) “Authorized electronic monitoring” means the placement of an electronic monitoring device in the room of a resident of an institution and making tapes or recordings with the device after making a request to the institution to allow electronic monitoring.

(b) “Electronic monitoring device:”

(1) includes:

(A) video surveillance cameras installed in the room of a resident; and

(B) audio devices installed in the room of a resident designed to acquire communications or other sounds occurring in the room; and

(2) does not include an electronic, mechanical, or other device that is specifically used for the nonconsensual interception of wire or electronic communications.

Section 3. [Criminal and Civil Liability.]

(a) It is a defense to prosecution under [insert citation], or any other statute of this state under which it is an offense to intercept a communication or disclose or use an intercepted communication, that the communication was intercepted by an electronic monitoring device placed in the room of a resident of an institution.

(b) This Act does not affect whether a person may be held to be civilly liable under other law in connection with placing an electronic monitoring device in the room of a resident of an institution or in connection with using or disclosing a tape or recording made by the device except:

(1) as specifically provided by this Act; or

(2) to the extent that liability is affected by:

(A) a consent or waiver signed under this Act; or

(B) the fact that authorized electronic monitoring is required to be conducted with notice to people who enter a resident’s room.

(c) A communication or other sound acquired by an audio electronic monitoring device installed under the provisions of this Act concerning authorized electronic monitoring is not considered to be:

(1) an oral communication as defined by [insert citation]; or

(2) a communication as defined [insert citation].

Section 4. [Covert Use of Electronic Monitoring Device; Liability of Department or Institution.]

(a) For purposes of this Act, the placement and use of an electronic monitoring device in the room of a resident is considered to be covert if:

(1) the placement and use of the device is not open and obvious; and

(2) the institution and the [department] are not informed about the device by the resident, by a person who placed the device in the room, or by a person who is using the device.

(b) The [department] and the institution may not be held to be civilly liable in connection with the covert placement or use of an electronic monitoring device in the room of a resident.

Section 5. [Required Form on Admission.] The [department] by rule shall prescribe a form that must be completed and signed on a resident’s admission to an institution by or on behalf of the resident. The form must state:
(1) that a person who places an electronic monitoring device in the room of a resident or who uses or discloses a tape or other recording made by the device may be civilly liable for any unlawful violation of the privacy rights of another;

(2) that a person who covertly places an electronic monitoring device in the room of a resident or who consents to or acquiesces in the covert placement of the device in the room of a resident has waived any privacy right the person may have had in connection with images or sounds that may be acquired by the device;

(3) that a resident or the resident’s guardian or legal representative is entitled to conduct authorized electronic monitoring under this Act, and that if the institution refuses to permit the electronic monitoring or fails to make reasonable physical accommodations for the authorized electronic monitoring that the person should contact the state [department of human services];

(4) the basic procedures that must be followed to request authorized electronic monitoring;

(5) the manner in which this Act affects the legal requirement to report abuse or neglect when electronic monitoring is being conducted; and

(6) any other information regarding covert or authorized electronic monitoring that the [department] considers advisable to include on the form.


(a) If a resident has capacity to request electronic monitoring and has not been judicially declared to lack the required capacity, only the resident may request authorized electronic monitoring under this Act, notwithstanding the terms of any durable power of attorney or similar instrument.

(b) If a resident has been judicially declared to lack the capacity required for taking an action such as requesting electronic monitoring, only the guardian of the resident may request electronic monitoring under this Act.

(c) If a resident does not have capacity to request electronic monitoring but has not been judicially declared to lack the required capacity, only the legal representative of the resident may request electronic monitoring under this Act. The [department] by rule shall prescribe:

(1) guidelines that will assist institutions, family members of residents, advocates for residents, and other interested people to determine when a resident lacks the required capacity; and

(2) who may be considered to be a resident’s legal representative for purposes of this Act, including:

(A) people who may be considered the legal representative under the terms of an instrument executed by the resident when the resident had capacity; and

(B) people who may become the legal representative for the limited purpose of this Act under a procedure prescribed by the [department].

Section 7. [Authorized Electronic Monitoring: Form of Request; Consent of Other Residents in Room.]

(a) A resident or the guardian or legal representative of a resident who wishes to conduct authorized electronic monitoring must make the request to the institution on a form prescribed by the [department].
(b) The form prescribed by the [department] must require the resident or the resident’s guardian or legal representative to:

(1) release the institution from any civil liability for a violation of the resident’s privacy rights in connection with the use of the electronic monitoring device;

(2) choose, when the electronic monitoring device is a video surveillance camera, whether the camera will always be unobstructed or whether the camera should be obstructed in specified circumstances to protect the dignity of the resident; and

(3) obtain the consent of other residents in the room, using a form prescribed for this purpose by the [department], if the resident resides in a multi-person room.

(c) Consent under Subsection (b)(3) may be given only:

(1) by the other resident or residents in the room;

(2) by the guardian of a person described by Subdivision (1), if the person has been judicially declared to lack the required capacity; or

(3) by the legal representative who under Section 6(c) of this Act may request electronic monitoring on behalf of a person described by Subdivision (1), if the person does not have capacity to sign the form but has not been judicially declared to lack the required capacity.

(d) The form prescribed by the [department] under Subsection (b)(3) must condition the consent of another resident in the room on the other resident also releasing the institution from any civil liability for a violation of the person’s privacy rights in connection with the use of the electronic monitoring device.

(e) Another resident in the room may:

(1) when the proposed electronic monitoring device is a video surveillance camera, condition consent on the camera being pointed away from the consenting resident; and

(2) condition consent on the use of an audio electronic monitoring device being limited or prohibited.

(f) If authorized electronic monitoring is being conducted in the room of a resident and another resident is moved into the room who has not yet consented to the electronic monitoring, authorized electronic monitoring must cease until the new resident has consented in accordance with this section.

(g) The [department] may include other information that the [department] considers to be appropriate on either of the forms that the [department] is required to prescribe under this Section.

(h) The [department] may adopt rules prescribing the place or places that a form signed under this section must be maintained and the period for which it must be maintained.

(i) Authorized electronic monitoring:

(1) may not commence until all request and consent forms required by this Section have been completed and returned to the institution; and

(2) must be conducted in accordance with any limitation placed on the monitoring as a condition of the consent given by or on behalf of another resident in the room.

Section 8. [Authorized Electronic Monitoring: General Provisions.]

(a) An institution shall permit a resident or the resident’s guardian or legal representative to monitor the room of the resident through the use of electronic monitoring devices.

(b) The institution shall require a resident who conducts authorized electronic monitoring or the resident’s guardian or legal representative to post and maintain a conspicuous notice at the
entrance to the resident’s room. The notice must state that the room is being monitored by an
electronic monitoring device.

(c) Authorized electronic monitoring conducted under this Act is not compulsory and
may be conducted only at the request of the resident or the resident’s guardian or legal
representative.

(d) An institution may not refuse to admit an individual to residency in the institution and
may not remove a resident from the institution because of a request to conduct authorized
electronic monitoring. An institution may not remove a resident from the institution because
covert electronic monitoring is being conducted by or on behalf of a resident.

(e) An institution shall make reasonable physical accommodation for authorized
electronic monitoring, including:

(1) providing a reasonably secure place to mount the video surveillance camera or
other electronic monitoring device; and

(2) providing access to power sources for the video surveillance camera or other
electronic monitoring device.

(f) The resident or the resident’s guardian or legal representative must pay for all costs
associated with conducting electronic monitoring, other than the costs of electricity. The
resident or the resident’s guardian or legal representative is responsible for:

(1) all costs associated with installation of equipment; and

(2) maintaining the equipment.

(g) An institution may require an electronic monitoring device to be installed in a manner
that is safe for residents, employees, or visitors who may be moving about the room. The
[department] may adopt rules regarding the safe placement of an electronic monitoring device.

(h) If authorized electronic monitoring is conducted, the institution may require the
resident or the resident’s guardian or legal representative to conduct the electronic monitoring in
plain view.

(i) An institution may but is not required to place a resident in a different room to
accommodate a request to conduct authorized electronic monitoring.

Section 9. [Reporting Abuse and Neglect.]

(a) For purposes of the duty to report abuse or neglect under [insert citation] and the
criminal penalty for the failure to report abuse or neglect under [insert citation], a person who is
conducting electronic monitoring on behalf of a resident under this Act is considered to have
viewed or listened to a tape or recording made by the electronic monitoring device on or before
the 14th day after the date the tape or recording is made.

(b) If a resident who has capacity to determine that the resident has been abused or
neglected and who is conducting electronic monitoring under this Act gives a tape or recording
made by the electronic monitoring device to a person and directs the person to view or listen to
the tape or recording to determine whether abuse or neglect has occurred, the person to whom
the resident gives the tape or recording is considered to have viewed or listened to the tape or
recording on or before the seventh day after the date the person receives the tape or recording for
purposes of the duty to report abuse or neglect under [insert citation] and of the criminal penalty
for the failure to report abuse or neglect under [insert citation].

(c) A person is required to report abuse based on the person’s viewing of or listening to a
tape or recording only if the incident of abuse is acquired on the tape or recording. A person is
required to report neglect based on the person’s viewing of or listening to a tape or recording only if it is clear from viewing or listening to the tape or recording that neglect has occurred.

(d) If abuse or neglect of the resident is reported to the institution and the institution requests a copy of any relevant tape or recording made by an electronic monitoring device, the person who possesses the tape or recording shall provide the institution with a copy at the institution’s expense.

Section 10. [Use of Tape or Recording by Agency or Court.]

(a) Subject to applicable rules of evidence and procedure and the requirements of this section, a tape or recording created through the use of covert or authorized electronic monitoring described by this Act may be admitted into evidence in a civil or criminal court action or administrative proceeding.

(b) A court or administrative agency may not admit into evidence a tape or recording created through the use of covert or authorized electronic monitoring or take or authorize action based on the tape or recording unless:

(1) if the tape or recording is a video tape or recording, the tape or recording shows the time and date that the events acquired on the tape or recording occurred;

(2) the contents of the tape or recording have not been edited or artificially enhanced;

(3) if the contents of the tape or recording have been transferred from the original format to another technological format, the transfer was done by a qualified professional and the contents of the tape or recording were not altered.

(c) A person who sends more than one tape or recording to the [department] shall identify for the [department] each tape or recording on which the person believes that an incident of abuse or evidence of neglect may be found. The [department] may adopt rules encouraging people who send a tape or recording to the [department] to identify the place on the tape or recording that an incident of abuse or evidence of neglect may be found.

Section 11. [Notice at Entrance to Institution.] Each institution shall post a notice at the entrance to the institution stating that the rooms of some residents may be being monitored electronically by or on behalf of the residents and that the monitoring is not necessarily open and obvious. The [department] by rule shall prescribe the format and the precise content of the notice.

Section 12. [Enforcement.]

(a) The [department] may impose appropriate sanctions under this Act on an administrator of an institution who knowingly:

(1) refuses to permit a resident or the resident’s guardian or legal representative to conduct authorized electronic monitoring;

(2) refuses to admit an individual to residency or allows the removal of a resident from the institution because of a request to conduct authorized electronic monitoring;

(3) allows the removal of a resident from the institution because covert electronic monitoring is being conducted by or on behalf of the resident; or

(4) violates another provision of this Act.

(b) The [department] may assess an administrative penalty under [insert citation] against an institution that:
(1) refuses to permit a resident or the resident’s guardian or legal representative to conduct authorized electronic monitoring;

(2) refuses to admit an individual to residency or allows the removal of a resident from the institution because of a request to conduct authorized electronic monitoring;

(3) allows the removal of a resident from the institution because covert electronic monitoring is being conducted by or on behalf of the resident; or

(4) violates another provision of this Act.

Section 13. [Criminal Offense.]

(a) A person who intentionally hampers, obstructs, tampers with, or destroys an electronic monitoring device installed in a resident’s room in accordance with this Act or a tape or recording made by the device commits an offense. An offense under this Section is a [Class B misdemeanor].

(b) It is a defense to prosecution under Subsection (a) that the person took the action with the effective consent of the resident on whose behalf the electronic monitoring device was installed or the resident’s guardian or legal representative.

Section 14. [Statement of Resident Rights.] The [department’s] Statement of Resident Rights as adopted under [insert citation] shall include language to address the resident’s right to place in the resident’s room an electronic monitoring device that is owned and operated by the resident or provided by the resident’s guardian or legal representative.

Section 15. [Monitoring] The [committee] shall monitor the implementation of this Act and study the impact of that law on the [department], institutions, and residents.

Section 16. [Forms.]

The [department of human services] shall devise a procedure under which current residents of convalescent and nursing homes and related institutions, or, when appropriate, another person on a resident’s behalf, are encouraged to sign the form that is required to be signed on admission under Section 5 of this Act.

Section 17. [Severability.] [Insert severability clause.]

Section 18. [Repealer.] [Insert repealer clause.]

Section 19. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act provides disability compensation for any individual who is unable to work due to the employee’s own sickness or injury, the sickness or injury of a family member, or the birth, adoption, or foster care placement of a new child.

This Act establishes, within the state disability insurance program, a family temporary disability insurance program to provide up to 6 weeks of wage replacement benefits to workers who take time off work to care for a seriously ill child, spouse, parent, domestic partner, or to bond with a new child. This Act provides the additional benefits through additional employee contributions.

This bill authorizes employers to require that employees use up to 2 weeks of earned but unused vacation leave prior to that employee’s receipt of these additional benefits, as provided, and specify that these provisions may not be construed to relieve an employer of any collective bargaining duties.

Submitted as:
California
SB 1661
Status: Enacted into law in 2002.

Comment:

This California law is cited as landmark legislation by the National Center on Caregiving. The Center’s June 2006 Issue Brief, Support for Working Family Caregivers: Paid Leave Policies in California and Beyond notes:

- The federal government has taken an important first step to support working caregivers through the Family and Medical Leave Act (FMLA) of 1993. The FMLA provides employees up to 12 weeks of unpaid leave per year for the birth or adoption of a child, or to care for themselves or a sick family member (spouse, child, or parent) without losing their jobs or health care insurance. The law applies to companies with 50 or more employees at or within seventy-five miles of the worksite. To qualify, an employee must have worked at least 1,250 hours during the 12-month period preceding the employee’s FMLA leave.

- When comparing the country’s paid family leave policies to other parts of the world, the U.S. lags behind nearly every other industrialized nation. At least 96 countries mandate paid annual leave, and 163 countries offer guaranteed paid leave to women for childbirth. Furthermore, 139 countries provide paid leave for short- or long-term illnesses, with 117 countries providing a week or more annually. The FMLA is a first step in supporting working caregivers, but is still a long way from the more extensive paid leave policies that are offered in most other industrialized nations.

- The California Paid Family Leave Law, the country’s most comprehensive paid family leave and medical insurance program, is a model for other states and the federal government.

- In June 2005, federal legislation (House Bill 3192c) was introduced to provide paid leave to workers who take time off under the FMLA for the birth or adoption of a child, to
care for a sick relative, or because the employee has a serious medical condition. Workers would receive their benefit through a new “Family and Medical Leave Trust Fund” financed from a 0.4 percent payroll contribution from employers. This federal benefit would cost the average employer about $11 per worker per month. In return, a worker would be able to receive up to 55 percent of his or her weekly salary for up to 12 weeks. This bill would also maintain the FMLA job protection for workers of companies with 50 or more employees.

- At the state level, several laws have been enacted to allow some employees to take certain kinds of leave with partial pay. Five states (CA, HI, NJ, NY, RI) and Puerto Rico have state-administered Temporary Disability Insurance (TDI) systems or require employers to offer TDI. This program provides workers who are temporarily disabled for medical reasons, including pregnancy and childbirth, with temporary leave with partial wage replacement. State-administered TDI programs are usually funded through some combination of an employee/employer shared payroll tax. Three states (MN, MT, NM) have laws or pilot initiatives for At-Home Infant Care. These programs provide eligible, lower income working parents with some wage replacement to provide care for their newborns or newly adopted children. At least six states (CA, CT, HI, MN, WA, WI) have laws requiring private sector employers to allow workers to use their sick leave to care for certain ill family members, such as a child, spouse, parent, parent-in-law, grandparent, or domestic partner, depending on the state. At least 40 states have laws or regulations allowing public employees to use sick leave to care for certain ill family members, such as a child, spouse, parent, parent-in-law, grandparent, or domestic partner, depending on the state.

- California has taken the critical first step in establishing the nation’s first partial paid leave law. Prior to the passage of this law, most low wage workers in the state, many of whom were female, had limited access to employer-sponsored fringe benefits providing for paid time off, including sick leave and paid vacation. Now, through the Paid Family Leave Law, more low wage workers have the ability to take paid time off to care for a newborn or sick family member.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
19-27B-01 Will Registry (Rejected)  

This Act directs the Secretary of State to create and maintain a will registry in which a testator or his attorney may register information regarding the testator's will. The information contained in such registry shall include the name of the person making the will, the date the will was made, and sufficient identification of the location of the will at the time of registration. The registry shall not contain a copy of the will. The fee for registration of a will shall be $10.00, which shall be deposited by the Secretary of State in the state General Fund.

Submitted as:
New Jersey  
Chapter 97 of 2005
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff:
This Act establishes a unified statewide lifespan respite services resource network to disseminate community lifespan respite services information resources.

Submitted as:
Michigan
Act 178 of 2004
Status: Enacted into law in 2004.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
According to New Jersey legislative staff, currently, the NJ-EDRS is already deployed on a limited, voluntary basis. Generally, doctors, hospital officials, nursing home administrators, funeral directors and local registrars and medical examiners need to fill out informational forms to complete the entry of a death certificate which is then reviewed by the local registrar and forwarded to the State registrar of vital statistics. This is a complex, paper-driven system that can create bottlenecks: death certificates must be issued before burial permits can be issued, and death certificates are an important requirement in the administration of decedent estates and the management of the assets of those estates for the survivors.

NJ-EDRS allows faster, more accurate, and more detailed filings, which can speed the provision of registry data, make it faster and easier to issue certified death records, and allows the Department of Health and Senior Services to collect and provide better statistics on mortality in New Jersey.

Specifically, this Act directs the State registrar of vital statistics in the Department of Health and Senior Services to establish and maintain the NJ-EDRS. The system is to be fully implemented no later than 18 months after the date of enactment of the bill, and is to be the required means of death registration and certification for any death or fetal death occurring in New Jersey, subject to any exception that may be approved by the State registrar in the case of a specific death or fetal death. All participants in the death registration process, including, but not limited to, the State registrar, local registrars, deputy registrars, alternate deputy registrars, sub-registrars, the State medical examiner, county medical examiners, funeral directors, attending, covering and resident physicians, licensed health care facilities, and other public or private institutions providing medical care, treatment or confinement to persons, will be required by the bill to use the NJ-EDRS to provide the information that is required of them by statute or regulation.

The bill requires that the NJ-EDRS, at a minimum, provide for:

- The direct transmission of burial permit documentation to the originating funeral home in an electronic form capable of output to a local printer;
- An overnight mail system for the delivery of NJ-EDRS-generated death certificates by local registrars, the cost of which is to be chargeable to the funeral director of record;
- An e-mail notification system to alert other responsible parties to pending cases, including notification to or from alternate local registrars;
- A systematic electronic payment method by which all fees are taken from accounts for which funeral homes are financially responsible and distributed, as appropriate, to the State registrar or local registrars as payment for the issuance of permits, the recording or records, the making of certified copies of death certificates, or for other charges that may be incurred;
- A legally binding system of digital authentication in lieu of signatures for the responsible parties and a means of ensuring database security that permits users to enter the system from multiple sites and includes contemporaneous and remote data security methods to protect the system from catastrophic loss or intrusions, as well as a method of data encryption for transmission;
- The capacity for authorized users to retrieve data comprising the death certification record;
The capacity to electronically amend and correct death records;

Electronic notification, upon completion of the death record and issuance of a burial permit, of the decedent's name, Social Security number and last known address and the informant to: the federal Social Security Administration, the federal Immigration and Naturalization Service, the Division of Medical Assistance and Health Services in the Department of Human Services, and such other governmental agencies as the State registrar determines will substantially contribute to safeguarding public benefit programs and diminish the criminal use of a decedent's name and other identifying information; and the New Jersey State Funeral Directors Association, in the case of a decedent participating in one of its funeral expense payment programs, in such a manner as to enable it to fulfill its fiduciary obligations for the payment of the decedent's final funeral and burial expenses;

Sufficient data documentation to meet contemporary and emerging standards and expectations of vital record archiving; and

Continuous 24-hour-a-day technical support for all authorized users of the system.

The bill establishes a "New Jersey Electronic Death Registration Support Fund" as a non-lapsing, revolving fund to be administered by the Commissioner of Health and Senior Services and credited with monies received from death registration recording fees paid by funeral homes pursuant to the bill. The monies in the fund and the interest earned thereon are to be used to meet the development and operational costs of the NJ-EDRS.

The bill stipulates that: the State Medical Examiner, county medical examiners, licensed health care facilities, other public or private institutions providing medical care, treatment or confinement to persons, funeral homes and physicians' private practice offices, as defined by the State registrar, are to acquire the electronic means prescribed by the State registrar to access the NJ-EDRS, or make other arrangements necessary for that purpose, no later than six months after enactment of the bill. Each shall employ at least one person who is qualified to use the NJ-EDRS, and is registered with the State registrar as an authorized user of the system, by virtue of completing a course of instruction on the NJ-EDRS provided by the State registrar or an authorized agent thereof, or satisfying other requirements established by the State registrar for this purpose.

The bill makes a person who violates the provisions of this bill, including a local registrar, deputy registrar, alternate deputy registrar or sub-registrar, who fails to perform his duty as required by law and by the directions of the State registrar thereunder, subject to a penalty of not less than $100 nor more than $250 for each first offense and not less than $250 nor more than $500 for each subsequent offense, recoverable in a civil action pursuant to the "Penalty Enforcement Law of 1999," N.J.S.A.2A:58-10 et seq. The bill authorizes the State registrar to refer a violation by a licensed physician, nurse or funeral director to the appropriate professional board in the Division of Consumer Affairs, which would assess the applicable penalty and assume enforcement responsibility on the same basis as it would for a violation of the statute or regulations governing the practice of those persons regulated by that board.

The bill also empowers the State registrar to suspend the authority of a local registrar, deputy registrar, alternate deputy registrar or sub-registrar to participate in the NJ-EDRS, and thereby preclude that person from issuing burial permits or registering deaths, if the State registrar determines that the applicable registration district is insufficiently equipped or provides untimely service with respect to the review and final authentication of records. In that event, the State registrar may assign a local registrar, deputy registrar, alternate deputy registrar or sub-
registrar from another registration district to substitute for the person in question until the applicable registration district meets the standards established by the State registrar.

The bill also tightens standards for obtaining a vital record. A local registrar, deputy registrar, alternate deputy registrar, sub-registrar, or registration district may only supply a copy of a birth, death, fetal death, or marriage record to a person with a specific relationship to the subject of the record or a legal authority. Those relationships and legal authorities are: the subject of the record; the parent, legal guardian or other legal representative of the subject of that record; the subject's spouse, child, grandchild or sibling, if of legal age, or the subject's legal representative; an agency of state or federal government for official purposes; a person possessing an order of a court of competent jurisdiction; or a person who is authorized under other emergent circumstances as determined by the Commissioner of Health and Senior Services.

Submitted as:
New Jersey
Chapter 221, Public Laws of 2003
Status: Enacted into law in 2004.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act requires nursing homes to post, in an area accessible to residents, employees, and visitors, the name, title, location, and telephone number of the staff person in the nursing home who is responsible for receiving complaints and conducting complaint investigations, and a procedure for communicating with that individual. In addition, nursing homes must have a staff person on duty 24 hours a day, 7 days a week, who is responsible for receiving complaints and conducting complaint investigations.

Submitted as:
Michigan
Act 11 of 2002
Status: Enacted into law in 2002.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
LEGISLATION

Encouraging Home- and Community-Based Care
This Act provides that someone in need of self-directed in-home care who is a recipient approved to receive certain Medicaid waiver services, or a participant in the state Community and Home Options to Institutional Care for the Elderly And Disabled (CHOICE) program, may employ registered personal services attendants to provide attendant care services. It exempts from these provisions home health agencies, hospice programs, and health care professionals who practice within the scope of their license. It allows a personal services attendant to perform certain self-directed in-home services and medical activities that, in the opinion of the attending physician, meet certain conditions and for which the attendant has received training or instruction on how to properly perform the medical activity from a licensed health professional.

The Act requires an individual in need of in-home care and the individual’s case manager to develop an authorized care plan. It provides that procedures must be adopted to receive and adjudicate certain complaints against personal services attendants.

The law also establishes a Governor’s Commission on Caregivers to study issues regarding the availability and quality of caregivers in long-term care health settings. It requires the commission to submit a report to the governor and legislative council.

Submitted as:
Indiana
SB 215 (enrolled version)

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “The Self-Directed In-Home Care Act.”

Section 2. [Definitions.] As used in this Act:

“Ancillary Services” means services ancillary to the basic services provided to an individual in need of self-directed in-home care who needs at least [one (1)] of the basic services as defined in this Section. The term includes the following:

1. Homemaker type services, including shopping, laundry, cleaning, and seasonal chores.
2. Companion type services, including transportation, letter writing, mail reading, and escort services.
3. Assistance with cognitive tasks, including managing finances, planning activities, and making decisions.

“Attendant Care Services” means those basic and ancillary services, which the individual chooses to direct and supervise a personal services attendant to perform, that enable an individual in need of self-directed in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care, and mobility.

“Basic Services” means a function that could be performed by the individual in need of self-directed in-home care if the individual were not physically disabled. The term includes the following:
(1) Assistance in getting in and out of beds, wheelchairs, and motor vehicles.

(2) Assistance with routine bodily functions, including:

(A) health-related services;
(B) bathing and personal hygiene;
(C) dressing and grooming; and
(D) feeding, including preparation and cleanup.

“Commission” refers to the [Governor's Commission on Caregivers] established by Section 12 of this Act.

“Health Facility” has the meaning as defined under [insert citation].

“Health-Related Services” means those medical activities that:

(1) In the opinion of the attending physician, could be performed by the individual if the individual were physically capable, and if the medical activity can be safely performed in the home; and

(2) The person who performs the medical activity has received training or instruction from a licensed health professional, within the professional's scope of practice, in how to properly perform the medical activity for the individual in need of self-directed services.

“Individual In Need of Self-Directed In-Home Care” means a disabled individual, or person responsible for making health related decisions for the disabled individual, who:

(1) Is approved to receive Medicaid waiver services under 42 U.S.C. 1396n(c), or is a participant in the state [Community and Home Options to Institutional Care Program] for the elderly and disabled under [insert citation];

(2) Is in need of attendant care services because of impairment;

(3) Requires assistance to complete functions of daily living, self-care, and mobility, including those functions included in attendant care services;

(4) Chooses to self-direct a paid personal services attendant to perform attendant care services; and

(5) Assumes the responsibility to initiate self-directed in-home care and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss a personal services attendant.

“Long Term Care Caregivers” means certified nurse aides, licensed practical nurses, and registered nurses employed in health facilities, home health care, and other community based settings as defined under [insert citations].

“Personal Services Attendant” means an individual who is registered to provide attendant care services under this Act and who has entered a contract with an individual and acts under the individual's direction to provide attendant care services that could be performed by the individual if the individual were physically capable.

“Self-Directed In-Home Health Care” means the process by which an individual, who is prevented by a disability from performing basic and ancillary services that the individual would perform if not disabled, chooses to direct and supervise a paid personal services attendant to perform those services in order for the individual to live in the individual's home and community rather than an institution.

Section 3. [Responsibility for Hiring, Recruiting, Training, Payment for Self-Directed In-Home Care.]

(a) Except as provided in subsection (b), an individual in need of self-directed in-home care is responsible for recruiting, hiring, training, paying, certifying any employment related...
documents, dismissing, and supervising in the individual’s home during service hours a personal service attendant who provides attendant care services for the individual.

(b) If an individual in need of self-directed in-home care is:
   (1) Less than twenty-one (21) years of age; or
   (2) Unable to direct in-home care because of a brain injury or mental deficiency; the individual’s parent, spouse, legal guardian, or a person possessing a valid power of attorney may make employment, care, and training decisions and certify any employment-related documents on behalf of the individual.

(c) An individual in need of self-directed in-home care or an individual under subsection (b) and the individual’s case manager shall develop an authorized care plan. The authorized care plan must include a list of weekly services or tasks that must be performed to comply with the authorized care plan.

Section 4. [Employing Personal Services Attendants for Self-Directed In-Home Care.]
(a) A personal services attendant who is hired by the individual in need of self-directed in-home care is an employee of the individual in need of self-directed in-home care.
(b) The division is not liable for any actions of a personal services attendant or an individual in need of self-directed in-home care.
(c) A personal services attendant and an individual in need of self-directed in-home care are each liable for any negligent or wrongful act or omission in which the person personally participates.

Section 5. [Contracting for Self-Directed In-Home Care.] The individual in need of self-directed in-home care and the personal services attendant must each sign a contract, in a form approved by the [insert agency], that includes, at a minimum, the following provisions:
(1) The responsibilities of the personal services attendant.
(2) The frequency the personal services attendant will provide attendant care services.
(3) The duration of the contract.
(4) The hourly wage of the personal services attendant. The wage may not be less than the federal minimum wage or more than the rate that the recipient is eligible to receive under a Medicaid home- and community-based services waiver or the [Community and Home Options to Institutional Care for the Elderly and Disabled Program for Attendant Care Services].
(5) Reasons and notice agreements for early termination of the contract.

Section 6. [Registration.]
(a) An individual who desires to provide attendant care services must register with the [insert agency] or with an organization designated by the [insert agency].
(b) The [insert agency] shall register an individual who provides the following:
   (1) A personal resume containing information concerning the individual’s qualifications, work experience, and any credentials the individual may hold. The individual must certify that the information contained in the resume is true and accurate.
   (2) The individual’s limited criminal history check from the state [central repository for criminal history information] under [insert citation] or another source allowed by law.
   (3) If applicable, the individual’s state [nurse aide registry] report from the state [department of health]. This subdivision does not require an individual to be a nurse aide.
(4) Three (3) letters of reference.

(5) A registration fee. The [insert agency] shall establish the amount of the registration fee, not to exceed [thirty (30)] dollars.

(6) Proof that the individual is at least [eighteen (18)] years old.

(7) Any other information required by the [insert agency].

(c) A registration is valid for [one (1)] year. A personal services attendant may renew the personal services attendant’s registration by updating any information in the file that has changed and by paying the fee required under subsection (a)(5). The limited criminal history check and report required under subsection (a)(2) and (a)(3) must be updated every [two (2)] years.

(d) The [insert agency] shall maintain a file for each personal services attendant that contains:

(1) Comments related to the provision of attendant care services submitted by an individual in need of self-directed in-home care who has employed the personal services attendant; and

(2) The items described in subsection (a)(1) through (a)(4).

(e) Upon request, the [insert agency] shall provide to an individual in need of self-directed in-home care the following:

(1) Without charge, a list of personal services attendants who are registered with the [insert agency] and available within the requested geographic area.

(2) A copy of the information of a specified personal services attendant who is on file with the [insert agency] under subsection

(f) The [insert agency] may charge a fee for shipping, handling, and copying expenses, not to exceed [five (5)] dollars per file.

Section 7. [Compensation for Self-Directed In-Home Care.]

(a) An individual may not provide attendant care services for compensation from Medicaid or the community and home options to institutional care for the elderly and disabled program for an individual in need of self-directed in-home care services unless the individual is registered under Section 6 of this Act.

(b) An individual who is a legally responsible relative of an individual in need of self-directed in-home care, including a parent of minor individual and a spouse, is precluded from providing attendant care services for compensation under this Act.

Section 8. [Rules and Medicaid Waiver.]

(a) The [insert agency] shall apply for any federal waivers necessary to implement this Act.

(b) The [insert agency] shall amend the state [Home and Community Based Services] waiver program under the state Medicaid plan to provide for the payment for attendant care services provided by a personal services attendant for an individual in need of self-directed in-home care under this Act, including any related record keeping and employment expenses.

However, the [insert agency] may not implement the provisions of this Act for Medicaid waiver recipients until:

(1) Any necessary waiver is approved; and

(2) The [insert agency] has filed an affidavit with the [governor] attesting that the appropriate federal waiver applied for under this Section is in effect. The [insert agency] shall
file the affidavit not later than [five (5)] days after the [insert agency] is notified that the waiver is approved.

(c) If the [insert agency] receives a waiver under this Section from the United States Department of Health and Human Services, and the governor [receives] the affidavit filed under subsection (b), the [insert agency] shall implement the waiver not later than [sixty (60)] days after the [governor] receives the affidavit.

Section 9. [Self-Directed In-Home Care: Eligibility Under Medicaid; Payment, Record Keeping.]
(a) The [insert agency] shall not, to the extent permitted by federal law, consider as income money paid under this Act to or on behalf of an individual in need of self-directed in-home care to enable the individual to employ registered personal services attendants, for purposes of determining the individual’s income eligibility for services under this Act.

(b) The [insert agency] shall adopt rules concerning:

1. The method of payment to a personal services attendant who provides authorized services under this Act; and
2. Record keeping requirements for personal attendant services.

(c) The [insert agency] may adopt other rules under [insert citation] as necessary to implement this Act.

Section 10. [Demonstration Projects.] The [insert agency] may:

1. Initiate demonstration projects to test new ways of providing attendant care services; and
2. Research ways to best provide attendant care services in urban and rural areas.

Section 11. [Complaints Concerning Self-Directed In-Home Care.] The [insert agency] shall adopt rules under [insert citation] concerning the following:

1. The receipt, review, and investigation of complaints concerning the neglect, abuse, mistreatment, or misappropriation of property of an individual in need of self-directed in-home care by a personal services attendant.
2. Establish notice and administrative hearing procedures in accordance with [insert citation].
3. Appeal procedures, including judicial review of administrative hearings.
4. Procedures to place a personal services attendant who has been determined to have been guilty of neglect, abuse, mistreatment, or misappropriation of property of an individual in need of self-directed in-home care on the state nurse aide registry.

Section 12. [Governor’s Commission on Caregivers.]
(a) The [Governor’s Commission on Caregivers] is established.

(b) The commission consists of the following members:

1. The [governor] or the governor’s designee, who shall serve as the chairperson.
2. The [state health commissioner] or the commissioner’s designee.
3. The [president of the state board of nursing] or the president’s designee.
4. The [secretary of family and social services] or the secretary’s designee.
5. The [chairman of the commission for higher education] or the chairman’s designee.
(6) The [state superintendent of public instruction] or the superintendent’s
designee.

(7) The [commissioner of the department of workforce development] or the
commissioner’s designee.

(8) The [director of the department of commerce] or the director’s designee.

(9) The [commissioner of the department of labor] or the commissioner’s
designee.

(10) [One (1)] member appointed by the [governor] to represent each of the
following organizations:

(A) The state [association of homes and services for the aging].

(B) The state [health care association].

(C) The state [association for home and hospice care].

(D) The state [nurses association].

(E) The state [health and hospital association].

(F) The state [home care task force].

(G) The state [association of area agencies on aging].

(H) [United Senior Action].

(I) The state [university school of nursing]

(J) [Ivy Tech State College].

(11) [One (1)] member appointed by the governor to represent a private
postsecondary educational institution that offers nursing degrees.

(c) The commission shall do the following:

(1) Review data and information on the availability of and need for long-term
care caregivers.

(2) Evaluate barriers to increasing the supply of long-term care caregivers.

(3) Evaluate the adequacy of existing training programs in the state for long-term
caregivers.

(4) Develop recommendations to increase the supply of long-term care caregivers,
including the following:

(A) Welfare to work programs.

(B) Worker recruitment and incentive programs.

(C) Immigration.

(D) Linkages between training programs and the long term care and senior
services industries.

(E) Cross-training of nurse aides across the continuum of long term care
services.

(F) Potential roles for various state agencies and educational institutions
represented on the commission.

(d) [Eleven (11)] members of the commission constitute a quorum.

(e) The affirmative votes of at least [eleven (11)] members of the commission are
required for the commission to take any action, including the approval of a final report.

(f) Each member of the commission who is not a state employee is entitled to the
minimum salary per diem provided by [insert citation].

(g) The commission may contract with a private individual or organization to provide the
staff support necessary for the operation of the commission, including conducting research and
developing the report required under subsection (h).
(h) The commission shall submit a report to the [governor] and the [legislative council] not later than [insert date].

Section 13. [Non-Applicability.] This Act does not apply to:

1. An individual who provides attendant care services and who is employed by and under the direct control of a home health agency as defined under [insert citation].

2. An individual who provides attendant care services and who is employed by and under the direct control of a licensed hospice program under [insert citation].

3. An individual who provides attendant care services and who is employed by and under the control of an employer that is not the individual who is receiving the services.

4. A practitioner as defined under [insert citation], who is practicing under the scope of the practitioner’s license as defined under [insert citation].

Section 14. [Severability.] [Insert severability clause.]

Section 15. [Repealer.] [Insert repealer clause.]

Section 16. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS

( ) Include in 2008 Supplement

( ) Reject

Comments/Note to staff:
26-28AS-25 Senior Living Program (2002 SSL)

This Act establishes a Senior Living Program to help low- and moderate-income seniors obtain services that permit them to stay in their homes instead of moving to a nursing home. The Act creates a Senior Living Trust Fund, provides for the development and provision of Senior Living Program information and electronic access to that information, a caregiver support and education program, and a senior living insurance policy and incentives study.

Submitted as:
Iowa
SF 2193
Status: Enacted into law in 2000.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title] This Act may be cited as the “Senior Living Program Act.”

Section 2. [Legislative Findings: Goal.]
1. The legislature finds that:
   a. The preservation, improvement, and coordination of the health care infrastructure of this state are critical to the health and safety of its citizens.
   b. An increasing number of seniors and people with disabilities in the state require long-term care services provided outside of a medical institution.
   c. A full array of long-term care services is necessary to provide cost-effective and appropriate services to the varied population of health care consumers.
   d. The supported development of long-term care alternatives, including assisted-living facility services, adult day care, and home and community-based services, is critical in areas of the state where such alternatives otherwise are not likely to be developed.
   e. Cost containment in the delivery of health care is necessary to improve services and access for all citizens of this state.
   f. Grants are necessary to cover the expenditures related to the development of alternative health care services. Development of these alternatives will improve access to and delivery of long-term care services to underserved people or in underserved areas, which will in turn contain or reduce the cost and improve the quality of health care services.
   g. A continuing source of funding is necessary to enhance the state's ability to meet the rising demand of seniors with low and moderate incomes in obtaining an appropriate variety of long-term care services.
2. The goal of this program is to create a comprehensive long-term care system that is consumer-directed, provides a balance between the alternatives of institutionally and non-institutionally provided services, and contributes to the quality of the lives of the citizens of this state.

Section 3. [Definitions.] As used in this Act:
1. “Affordable” means rates for payment of services which do not exceed the rates established for providers of medical and health services under the [Medical Assistance Program] with eligibility for an individual equal to the eligibility for medical assistance pursuant to [insert citation]. In relation to services provided by a provider of services under a home and community-based waiver, “affordable” means that the total monthly cost of the home and community-based waiver services provided do not exceed the cost for that level of care as established by rule by the [department of human services], in consultation with the [department of elder affairs].

2. “Assisted living” means assisted living as defined in section 14 of this Act.

3. “Case mix reimbursement” means a reimbursement methodology that recognizes the acuity and need level of the residents of a nursing facility.

4. “Long-term care alternatives” means those services specified under the medical assistance program as home and community-based waiver services for elder people or adults with disabilities, elder group homes certified under [insert citation], [assisted-living programs] certified under [insert citation], and the PACE program.

5. “Long-term care provider” means a provider of services through long-term care alternatives.

6. “Long-term care service development” means any of the following:
   a. The remodeling of existing space and, if necessary, the construction of additional space required to accommodate development of long-term care alternatives, excluding the development of assisted-living programs or elder group home alternatives.
   b. New construction for long-term care alternatives, excluding new construction of assisted-living programs or elder group homes, if the [senior living coordinating unit] determines that new construction is more cost-effective than the conversion of existing space.

7. “Nursing facility” means a licensed nursing facility as defined in [insert citation] or a licensed hospital as defined in [insert citation], a distinct part of which provides long-term care nursing facility beds.

8. “Nursing facility conversion” means any of the following:
   a. The remodeling of nursing facility space existing on [insert date], and certified for medical assistance nursing facility reimbursement and, if necessary, the construction of additional space required to accommodate an assisted-living program.
   b. New construction of an assisted-living program if existing nursing facility beds are no longer licensed and the [senior living coordinating unit] determines that new construction is more cost-effective than the conversion of existing space.

9. “PACE program” means a program of all-inclusive care for the elderly established pursuant to 42 U.S.C. § 1396(u)(4) that provides delivery of comprehensive health and social services to seniors by integrating acute and long-term care services, and that is operated by a public, private, nonprofit, or proprietary entity. “Pre-PACE program” means a PACE program in the initial start-up phase that provides the same scope of services as a PACE program.

10. “People with disabilities” means individuals [eighteen (18)] years of age or older with disabilities as disability is defined in [insert citation].

11. “Senior” means elder as defined in [insert citation] and as defined under the PACE program pursuant to 42 U.S.C. § 1396(u)(4).

12. “Senior living coordinating unit” means the [senior living coordinating unit] created within the [department of elder affairs] pursuant to [insert citation], or its designee.
13. “Senior living program” means the Senior Living Program created in this Act to provide for long-term care alternatives, long-term care service development, and nursing facility conversion.

Section 4. [Senior Living Trust Fund.]
1. A Senior Living Trust Fund is created in the state treasury under the authority of the [department of human services]. Money received through intergovernmental agreements for the Senior Living Program and money received from sources, including grants, contributions, and participant payments, shall be deposited in the fund.
2. The [department of human services], upon receipt of federal revenue on or after [insert date], from public nursing facilities participating in the medical assistance program, shall deposit the federal revenue received in the trust fund, less a sum of [five thousand (5,000)] dollars as an administration fee per participating public nursing facility.
3. Money deposited in the trust fund shall be used only for the purposes of The Senior Living Program as specified in this Act.
4. The trust fund shall be operated in accordance with the guidelines of the Health Care Financing Administration of the United States Department of Health and Human Services. The trust fund shall be separate from the General Fund of the state and shall not be considered part of the General Fund of the state. The money in the trust fund shall not be considered revenue of the state, but rather shall be funds of the Senior Living Program. The money in the trust fund shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes of this Act. Interest or earnings on money deposited in the trust fund shall be credited to the trust fund.
5. The [department of human services] shall adopt rules to administer the trust fund and to establish procedures for participation by public nursing facilities in the intergovernmental transfer of funds to the Senior Living Trust Fund.
6. The [treasurer] of this state shall provide a quarterly report of trust fund activities and balances to the [senior living coordinating unit].

Section 5. [Allocations: Senior Living Trust Fund.]
1. Money deposited in the Senior Living Trust Fund created by this Act shall be used only as provided in appropriations from the trust fund to the [department of human services] and the [department of elder affairs], and for purposes, including the awarding of grants, as specified in this Act.
2. Money in the trust fund is allocated, subject to their appropriation by the [Legislature], as follows:
   a. To the [department of human services], a maximum of [insert amount] dollars for the fiscal period beginning [insert date], and ending on or before [insert date], to be used for the conversion of existing nursing facility space and development of long-term care alternatives.
   b. To the [department of elder affairs], an amount necessary, annually, for expenses incurred in implementation and administration of the long-term care alternatives programs and for delivery of long-term care services to seniors with low or moderate incomes.
   c. To the [department of human services], an amount necessary, annually, for all of the following:
      (1) Expenses incurred in implementation of the Senior Living Program.
(2) Expenses incurred in administration of medical assistance home and community-based waivers and the PACE program due to implementation of the Senior Living Trust Fund.

(3) Expenses incurred due to increased service delivery provided under medical assistance home and community-based waivers as a result of nursing facility conversions and long-term care service development, for the fiscal period beginning [insert date], and ending on or before [insert date].

(4) Expenses incurred in program administration related to implementation of nursing facility case mix reimbursement under the medical assistance program.

d. To the [department of human services], an amount necessary to provide funding for nursing facility provider reimbursements, using the percentile-based reimbursement system, and to provide funding for the transition to a case-mix reimbursement system. Funding shall be provided under this section for the percentile-based reimbursement system, until such time as the case-mix reimbursement system is fully implemented.

e. To the [department of human services] an amount necessary, annually, for additional expenses incurred relative to implementation of the senior living program in assisting home and community-based waiver consumers with rent expenses pursuant to the state supplementary assistance program.

3. Any funds remaining after disbursement of money under subsection 2 shall be invested with the interest earned to be available in subsequent fiscal years for the purposes provided in subsection 2, paragraph “b”, and subsection 2, paragraph “c”, subparagraphs (1) and (2).

Section 6. [Nursing Facility Conversion and Long-Term Care Service Development Grants.]

1. The [department of human services], at the direction of the [senior living coordinating unit], may use money appropriated to the [department] from the Senior Living Trust Fund to award grants to any of the following:

a. A licensed nursing facility that has been an approved provider under the medical assistance program for the [three (3)] year period prior to application for the grant. The grant awarded may be used to convert all or a portion of the licensed nursing facility to a certified assisted-living program and may be used for capital or one-time expenditures, including but not limited to start-up expenses, training expenses, and operating losses for the first year of operation following conversion associated with the nursing facility conversion.

b. A long-term care provider or a licensed nursing facility that has been an approved provider under the medical assistance program for the three-year period prior to application for the grant or a provider that will meet applicable medical assistance provider requirements as specified in subsection 2, paragraph “c” or “d.” The grant awarded may be used for capital or one-time expenditures, including but not limited to start-up expenses, training expenses, and operating losses for the first year of operation for long-term care service development.

2. A grant shall be awarded only to an applicant who meets all of the following criteria, as applicable to the type of grant:

a. The applicant is a long-term care provider or a nursing facility that is located in an area determined by the [senior living coordinating unit] to be underserved with respect to a
particular long-term care alternative service, and that has demonstrated the ability or potential to provide quality long-term care alternative services.

b. The applicant is able to provide a minimum matching contribution of [twenty (20)] percent of the total cost of any conversion, remodeling, or construction.

c. The applicant is applying for a nursing facility conversion grant and is able to demonstrate all of the following:

(1) Conversion of the nursing facility or a distinct portion of the nursing facility to an assisted-living program is projected to offer efficient and economical care to people who require long-term care services in the service area.

(2) Assisted-living services are otherwise not likely to be available in the area for people who are eligible for services under the medical assistance program.

(3) The resulting reduction in the availability of nursing facility services is not projected to cause undue hardship on those people who require nursing facility services for a period of at least [ten (10)] years.

(4) Public support following a community-based assessment.

(5) Conversion of the nursing facility is projected to result in a lower per client reimbursement cost to the grant applicant under the medical assistance program.

d. The applicant is applying for a long-term care service development grant and is able to demonstrate all of the following:

(1) Long-term care service development is projected to offer efficient and economical care to people who require long-term care services in the service area.

(2) The proposed long-term care alternative is otherwise not likely to be available in the area for people who are eligible for services under the medical assistance program.

(3) Public support following a community-based assessment.

e. The applicant agrees to do all of the following as applicable to the type of grant:

(1) Participate and maintain a minimum medical assistance client base participation rate of [forty (40)] percent, subject to the demand for participation by people who are eligible for medical assistance.

(2) Provide a service delivery package that is affordable for those people who are eligible for services under the medical assistance home and community-based services waiver program.

(3) Provide a refund to the Senior Living Trust Fund, on an amortized basis, in the amount of the grant, if the applicant or the applicant’s successor in interest ceases to operate an affordable long-term care alternative within the first [ten (10)] year period of operation following the awarding of the grant or if the applicant or the applicant’s successor in interest fails to maintain a participation rate of [forty (40)] percent in accordance with subparagraph (1).

3. The [department of human services] shall adopt rules in consultation with the [senior living coordinating unit] to provide all of the following:

a. An application process and eligibility criteria for the awarding of grants. The eligibility criteria shall include but are not limited to the applicant’s demonstration of an affordable service package, the applicant’s use of the funds for allowable costs, and the applicant’s ability to refund the funds if required under subsection 2, paragraph “e,” subparagraph (3). The primary eligibility criterion used shall be the applicant’s potential impact
on the overall goal of moving toward a balanced, comprehensive, affordable, high quality, long-term care system.

b. Criteria to be used in determining the amount of the grant awarded.

c. Weighted criteria to be used in prioritizing the awarding of grants to individual grantees during a grant cycle. Greater weight shall be given to the applicant’s demonstration of potential reduction of nursing facility beds, the applicant’s ability to meet demonstrated community need, and the established history of the applicant in providing quality long-term care services.

d. Policies and procedures for certification of the matching funds required of applicants under subsection 2, paragraph “b.”

e. Other procedures the [department of human services] deems necessary for the proper administration of this section, including but not limited to the submission of progress reports on a bimonthly basis to the [senior living coordinating unit].

4. The [department of human services] shall adopt rules to ensure that a nursing facility that receives a nursing facility conversion grant allocates costs in an equitable manner.

5. In addition to the types of grants described in subsection 1, the [department of human services], at the direction of the [senior living coordinating unit], may also use money appropriated to the [department] from the Senior Living Trust Fund to award grants, of not more than [one hundred thousand (100,000)] dollars per grant, to licensed nursing facilities that are awarded nursing facility conversion grants and agree, as part of the nursing facility conversion, to also provide adult day care, child care for children with special needs, safe shelter for victims of dependent adult abuse, or respite care.

6. The [department of human services] shall establish a calendar for receiving and evaluating applications and for awarding of grants.

7. a. The [department of human services] shall develop a cost report to be completed by a grantee which includes, but is not limited to, revenue, costs, loans undertaken by the grantee, fixed assets of the grantee, a balance sheet, and a profit and loss statement.

   b. Grantees shall submit, annually, completed cost reports to the [department of human services] regarding the project for a period of [ten (10)] years following the date of initial operation of the grantee’s long-term care alternative.

8. The [department of human services], in consultation with the [department of elder affairs], shall provide annual reports to the [governor] and the [Legislature] concerning grants awarded. The annual report shall include the total number of applicants and approved applicants, an overview of the various grants awarded, and detailed reports of the cost of each project funded by a grant and information submitted by the approved applicant.

9. For the purpose of this section, “underserved” means areas in which [four and four-tenths (4.4)] percent of the number of people who are [sixty-five (65)] years of age and older is not greater than the number of currently licensed nursing facility beds and certified assisted-living units. In addition, the [department], in determining if an area is underserved, may consider additional information gathered through the [department’s] own research or submitted by an applicant, including but not limited to any of the following:

   a. Availability of and access to long-term care alternatives relative to people who are eligible for medical assistance.

   b. The current number of seniors and people with disabilities and the projected number of these people.
c. The current number of seniors and people with disabilities requiring professional nursing care and the projected number of these people.

d. The current availability of long-term care alternatives and any known changes in the availability of such alternatives.

10. This section does not create an entitlement to any funds available for grants under this section, and the [department of human services] may only award grants to the extent funds are available and within its discretion, to the extent applications are approved.

11. In addition to any other remedies provided by law, the [department of human services] may recoup any grant funding previously awarded and disbursed to a grantee or the grantee’s successor in interest and may reduce the amount of any grant awarded, but not yet disbursed, to a grantee or the grantee’s successor in interest, by the amount of any refund owed by a grantee or the grantee’s successor in interest pursuant to subsection 2, paragraph “e,” subparagraph (3).

12. The [senior living coordinating unit] shall review projects that receive grants under this section to ensure that the goal to provide alternatives to nursing facility care is being met and that an adequate number of nursing facility services remains to meet the needs of the citizens of this state.

Section 7. [Home and Community-Based Services for Seniors.]

1. Beginning [insert date], the [department of elder affairs], in consultation with the [senior living coordinating unit], shall use funds appropriated from the Senior Living Trust Fund for activities related to the design, maintenance, or expansion of home and community-based services for seniors, including but not limited to adult day care, personal care, respite, homemaker, chore, and transportation services designed to promote the independence of and to delay the use of institutional care by seniors with low and moderate incomes. At any time that money is appropriated, the [department of elder affairs], in consultation with the senior living coordinating unit, shall disburse the funds to the area agencies on aging.

2. The [department of elder affairs] shall adopt rules, in consultation with the [senior living coordinating unit] and the [area agencies on aging] to provide all of the following:

   a. (1) The criteria and process for disbursement of funds, appropriated in accordance with subsection 1, to [area agencies on aging].

      (2) The criteria shall include, at a minimum, all of the following:

         (a) A distribution formula that triple weights all of the following:

            (i) People who are [seventy (75)] years of age and older.

            (ii) People who are aged [sixty (60)] and older who are members of a racial minority.

            (iii) People who are [sixty (60)] years of age and older who reside in rural areas as defined in the federal Older Americans Act.

            (iv) People who are [sixty (60)] years of age and older who have incomes at or below the poverty level as defined in the federal Older Americans Act.

         (b) A distribution formula that single weights people who are [sixty (60)] years of age and older who do not meet the criteria specified in subparagraph subdivision (a).

   b. The criteria for long-term care providers to receive funding as subcontractors of the area agencies on aging.
c. Other procedures the [department of elder affairs] deems necessary for the proper administration of this section, including but not limited to the submission of progress reports, on a bimonthly basis, to the [senior living coordinating unit].

3. This section does not create an entitlement to any funds available for disbursement under this section and the [department of elder affairs] may only disburse money to the extent funds are available and, within its discretion, to the extent requests for funding are approved.

4. Long-term care providers that receive funding under this section shall submit annual reports to the appropriate [area agency on aging]. The [department of elder affairs] shall develop the report to be submitted, which shall include, but is not limited to, units of service provided, the number of service recipients, costs, and the number of units of service identified as necessitated but not provided.

5. The [department of elder affairs], in cooperation with the [department of human services], shall provide annual reports to the governor and the [Legislature] concerning the impact of money disbursed under this section on the availability of long-term care services in this state. The reports shall include the types of services funded, the outcome of those services, and the number of people receiving those services.

Section 8. [PACE Program.]

1. A person operating a PACE program shall have a PACE program agreement with the Health Care Financing Administration of the United States Department of Health and Human Services, shall enter a contract with the [department of human services] and shall comply with 42 U.S.C. § 1396(u)(4) and all regulations promulgated pursuant to that section.

2. Services provided under a PACE or pre-PACE program shall be provided on a capitated basis.

3. A pre-PACE program may contract with the [department of human services] to provide services to people who are eligible for medical assistance, on a capitated basis, for a limited scope of the PACE service package through a prepaid health plan agreement, with the remaining services reimbursed directly to the service providers by the medical assistance or federal Medicare programs.

4. PACE and pre-PACE programs are not subject to regulation under [insert citation].

5. A PACE or pre-PACE program shall, at the time of entering into the initial contract and of renewal of a contract with the [department of human services], demonstrate cash reserves in an amount established by rule of the [department] to cover expenses in the event of insolvency.

Section 9. [Senior Living Program Information: Electronic Access, Education and Advisory Council.]

1. The [department of elder affairs] and the [area agencies on aging], in consultation with the [senior living coordinating unit], shall create, on a county basis, a database directory of all health care and support services available to seniors. The [department of elder affairs] shall make the database electronically available to the public, and shall update the database on at least a monthly basis.

2. The [department of elder affairs] shall seek foundation funding to develop and provide an educational program for people who are aged [twenty-one (21)] and older which assists participants in planning for and financing health care services and other supports in their senior years.
3. The [department of human services] shall develop and distribute an informational packet to the public that explains, in layperson terms, the law, regulations, and rules under the medical assistance program relative to health care services options for seniors, including but not limited to those relating to transfer of assets, prepaid funeral expenses, and life insurance policies.

4. The [director of human services], the [director of the department of elder affairs], the [director of public health], the [director of the department of inspections and appeals], the [director of revenue and finance], and the [commissioner of insurance] shall constitute a [senior advisory council] to provide oversight in the development and operation of all informational aspects of the Senior Living Program under this section.

Section 10. [Caregiver Support: Access And Education Programs.]

The [department of human services] and the [department of elder affairs], in consultation with the [senior living coordinating unit], shall implement a caregiver support program to provide access to respite care and to provide education to caregivers in providing appropriate care to seniors and people with disabilities.

Section 11. [Future Repeal.] Section 6 of this Act is repealed on [June 30, 2005]. However, grants awarded and money appropriated for grants on or before [June 30, 2005], shall be disbursed to eligible applicants after that date if necessary.

Section 12. [Resident Assessment.] A nursing facility as defined in [insert citation] shall complete a resident assessment prior to initial admission of a resident and periodically during the resident’s stay in the facility. The assessment shall be completed for each prospective resident and current resident regardless of payer source. The nursing facility may use the same resident assessment tool required for certification of the facility under the medical assistance and federal Medicare programs to comply with this section.

Section 13. [Long-Term Care Senior Living Coordinating Unit.]

1. A long-term care senior living coordinating unit is created within the [department of elder affairs]. The membership of the coordinating unit consists of:
   a. The [director of human services].
   b. The [director of the department of elder affairs].
   c. The [director of public health].
   d. The [director of the department of inspections and appeals].
   e. [Two (2)] members appointed by the [governor].
   f. [Four (4)] members of the [Legislature], as ex officio, nonvoting members.

2. The legislative members of the unit shall be appointed by the [majority leader of the Senate], after consultation with the [president of the Senate] and the [minority leader of the Senate], and by the [speaker of the House], after consultation with the [majority leader] and the [minority leader of the House of Representatives].

3. Non-legislative members shall receive actual expenses incurred while serving in their official capacity and may also be eligible to receive compensation as provided in [insert citation]. Legislative members shall receive compensation pursuant to [insert citation].

4. The [long-term care senior living coordinating unit] shall:
a. Develop, for legislative review, the mechanisms and procedures necessary to implement, utilizing current personnel, a case-managed system of long-term care based on a uniform comprehensive assessment tool.

b. Develop common intake and release procedures for the purpose of determining eligibility at one point of intake and determining eligibility for programs administered by the [departments of human services, public health, and elder affairs], such as the medical assistance program, federal food stamp program, and homemaker-home health aide programs.

c. Develop common definitions for long-term care services.

d. Develop procedures for coordination at the local and state level among the providers of long-term care, including when possible co-campusing of services. The [director of the department of general services] shall give particular attention to this section when arranging for office space for these three departments.

e. Prepare a long-range plan for the provision of long-term care services within the state.

f. Propose rules and procedures for the development of a comprehensive long-term care and community-based services program.

g. Submit a report of its activities to the [governor] and [Legislature] on [January 15] of each year.

h. Provide direction and oversight for disbursement of money from the Senior Living Trust Fund created by this Act.

i. Consult with the state universities and other institutions with expertise in the area of senior issues and long-term care.

Section 14. [Assisted Living Programs.] “Assisted living” means provision of housing with services that may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living to [six (6)] or more tenants in a physical structure that provides a homelike environment. “Assisted living” also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. “Assisted living” includes the provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also included.

Section 15. [Senior Living Insurance and Incentives Interim Study.] The [legislative council] is requested to authorize a [senior living insurance and incentives study committee] to review current long-term care insurance laws, current long-term care insurance options available in the state, the types of services covered under a long-term care insurance option, and incentives for the purchase of long-term care insurance including, but not limited to, tax credits. The [study committee] shall include input from consumers, consumer advocates, the insurance industry, and the health care industry. The [study committee] shall submit a report of findings and recommendations to the [governor] and the [Legislature] on or before [insert date].

Section 16. [Reimbursement Methodology Task Force.] The [department of human services] shall convene a [task force] consisting of the members of the [senior living coordinating unit], representatives of the nursing facility industry, consumers and consumer advocates to develop a case-mix reimbursement methodology. The methodology developed shall include a limited number of levels of reimbursement. The task force shall submit a report of the
reimbursement methodology developed to the [governor] and the [Legislature] on or before [insert date]. The [department of human services] shall also include in the report a summary of the expenditures for nursing facility conversion and for long-term care service development.

Section 17. [Residential Care Facilities: Application of Program.] The [department of human services] shall review and shall make recommendations to the [Legislature] on or before [insert date], relating to the feasibility of applying the [Senior Living Program] and any changes in the reimbursement methodology to residential care facilities.

Section 18. [Maintenance of Fiscal Effort.] The fiscal effort, existing on [insert date], represented by appropriations made for long-term care services by the [Legislature], shall be maintained and a reduction shall not be made in such appropriations to the [department of human services] or the [department of elder affairs] for those services as a result of this Act.

Section 19. [Department of Elder Affairs Appropriation.] There is appropriated from the Senior Living Trust Fund created by this Act to the [department of elder affairs] for [fiscal year], the following amount, or so much thereof as is necessary, to be used for the purposes designated:

1. For the development of a comprehensive senior living program, including program administration and costs associated with implementation, salaries, support, maintenance, miscellaneous purposes, and for not more than [seven (7)] full-time equivalent positions: [insert amount].

2. The [department of elder affairs] may adopt emergency rules to carry out the provisions of this section.

Section 20. [Department of Human Services Appropriation.]

1. There is appropriated from the Senior Living Trust Fund created by this Act to the [department of human services] for [fiscal year], the following amounts, or so much thereof as is necessary, to be used for the purposes designated:

   a. To provide grants to nursing facilities for conversion to assisted living programs or to provide long-term care alternatives and to provide grants to long-term care providers for development of long-term care alternatives: [insert amount].

   b. To supplement the medical assistance appropriation and to provide reimbursement for health care services and rent expenses to eligible people through the home and community-based services waiver and the state supplementary assistance program, including program administration and data system costs associated with implementation, salaries, support, maintenance, miscellaneous purposes, and for not more than [five (5)] full-time equivalent positions: [insert amount].

   c. To implement nursing facility provider reimbursement at the seventieth percentile and case-mix reimbursement methodology changes: [insert amount].

2. The [department] shall transfer these funds to supplement other appropriations to the [department of human services] to carry out the purposes of this subsection. The total amount expended by the [department of human services] in [fiscal year] reimbursements under both the seventieth percentile and the case-mix reimbursement methodologies shall not exceed the amount appropriated in this subsection.

Section 21. [Emergency Rules.]
1. The [department of human services] and the [department of elder affairs] may adopt emergency rules to implement this Act.

2. If the [department of human services] or the [department of elder affairs] adopts emergency rules to implement this Act, the rules shall become effective immediately upon filing, unless a later effective date is specified in the rules. Any rules adopted in accordance with the provisions of this section shall also be published as notice of intended action as provided in [insert citation].

Section 22. [Retroactive Applicability.] The section in this Act that creates section 6 of this Act as it relates to receipt of federal funding, is retroactively applicable to [October 1, 1999].

Section 23. [Severability.] [Insert severability clause.]

Section 24. [Repealer.] [Insert repealer clause.]

Section 25. [Effective Date.] [Insert effective date.]

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
26-28AS-26 Long-Term Care Plans and Least Restrictive Environment  CT

This Act establishes a Long-Term Care Planning Committee for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. The bill directs such policy and plan to provide that people with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. Such plan shall integrate the three components of a long-term care system including home and community-based services, supportive housing arrangements and nursing facilities.

Submitted as:
Connecticut
Public Act No. 05-14
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
Under existing law, if an individual was being served in a nursing facility and desired to live in the community but required the assistance of community-based services to live in the community, there was no mechanism for the funding to follow the client to receive services provided in a community setting.

This Act permits transferring funds to community-based programs when an individual leaves a nursing facility to live in the community with the assistance of community-based services.

Submitted as:
Texas
HB 1867 (enrolled version)
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
(    ) Include in 2008 Supplement
(    ) Reject

Comments/Note to staff:
Senator Kemp Hannon, this Act’s sponsor, says this Act:

“Provides numerous protections to consumers and strong direction to assisted living operators. With official state oversight of all assisted living facilities, the Department of Health will ensure a basic standard of operation, clarification of the assisted living product for consumers, and standardized consumer protections and disclosures. Full protections, however, will only be available when the complete regulations contemplated by the Act are adopted.

For the first time in New York State, the Assisted Living Reform Act officially defines an assisted living residence as "an entity which houses 5 or more adult residents and provides/arranges for housing, daily food service, 24-hour on-site monitoring, case management, personal care and home care based on the mandatory development of an individualized service plan for each resident." In addition, the new law will require all facilities which market themselves as assisted living residences to be licensed by the state Department of Health. Facilities who allow residents to age in place by providing additional care and services must be licensed and additionally certified by the state as an enhanced assisted living residence. An enhanced assisted living residence must meet further requirements in order to provide the additional services and care. Even further certification is required for specialized enhanced assisted living facilities which are specially equipped to provide services and care for individuals with chronic conditions such as dementia.

While the details and requirements of these licensure and certification practices are still being developed, the law clearly outlines important consumer protections disclosed through the mandatory written residency agreement. The residency agreement must be written in plain language and in an easily readable text format and include the following consumer protections:

- The criteria used by the residence to determine admission to the residence and the criteria which must be met in order to maintain residency at the facility,
- The base rate for a residence in the facility,
- The services included in the base rate fee,
- A list and description of any other services available at the facility,
- The fee scale for additional services available but not included in the base rate,
- Billing and payment procedures,
- The name of the resident’s representative and/or the resident’s legal representative,
- Name, telephone number, street address and mailing address of the facility,
- The name and mailing address of the owner and of the operator of the facility,
- The licensure and, if applicable, additional certification status of the residence,
- The license and/or certification status of the outside agencies providing home care, personal care, and other services at the residence,
- Steps to take to change or modify the written residency agreement,
- A description of the complaint resolution process,
- Procedures for the resident to terminate the written residence agreement, including the refund policies, and
• Procedures and justifications necessary for the residency operator to terminate the agreement, discharge the patient, or transfer the patient to another level of care, and the effective dates of the written residency agreement.

In addition to these disclosures in the written residency agreement, the assisted living facility is also required to provide each resident or anyone interested in becoming a resident the following:
• The consumer information guide to assisted living which will be produced by the Department of Health,
• Information on how residents may arrange for services independently of the facility if they are needed,
• A statement assuring the resident they have the right to choose their own health care providers,
• The availability of Medicare funds to pay for care,
• The facility’s toll-free number to use in making complaints, and
• Information on the state’s Ombudsman services for questions and concerns about long term care in the state.”

Submitted as:
New York
Article 46B (S.7748/A.11820)
Status: Enacted into law in 2004.

Comment:

For Release: October 26, 2004

Governor Signs Historic Law to Protect Assisted Living Residents: Measure Will Offer New York's Seniors Better, Safer Options for Their Long Term Care

Governor George E. Pataki today signed into law historic assisted living reform legislation he has long-championed, which will provide New York seniors with greater protections and improved long-term care options.

"This new law will provide added protections for our seniors, encourage new development of much-needed assisted living residences across the state, and hold operators of these facilities accountable for the services they provide," Governor Pataki said. "We're proud that with this powerful new law, New York's families will know that their loved ones are receiving the services they need in a safe and supervised environment."

Senator Kemp Hannon, Chairman of the Senate Health Committee, said, "Assisted living has become an integral part of long term health care services here on Long Island and across New York State, necessitating protections for residents and consumers. With this new legislation, we are recognizing this continuum of long term care and simultaneously establishing safeguards and disclosures to provide the highest quality of care and services to all of our seniors."

Senator George D. Maziarz said, "With the Governor's signature today, the assisted living reforms that we have sought for years will finally come into being. From constituents to industry experts, many have been involved in getting this done, and we can all be proud of our efforts. As
prime sponsor of the bill, I can confidently say that we are making sure that assisted living facilities are properly run, and that seniors' needs are being met every step of the way. This truly is a great day for the seniors of New York State."

Senator Martin Golden, Chairman of the Senate Committee on Aging, said, "This is a great day for New York's seniors and their families because the adoption of the Assisted Living Reform Act will provide for the necessary protections to age in place. I have worked with Governor George Pataki, my colleagues and numerous senior action groups to build the framework needed to protect the health and welfare of our seniors and also to provide peace of mind to their families. With this law, we have taken great strides forward to increase the protections afforded to our aging population. This truly is a momentous accomplishment for all seniors and their families across the State of New York."

Assemblyman Steve Englebright said, "After today, 'assisted living' will be defined in law and health and safety standards will be assured by the Department of Health licensing and oversight. For seniors and their families, this means that the uncertainty and abuses that have too often accompanied a decision to enter an assisted living facility will be replaced by predictability and a well-founded sense of security and well-being."

Lois Aronstein, AARP New York State Director said, "AARP commends the leadership of Governor Pataki for long championing senior housing reform legislation and signing this bill into law. Not only does this new law define the future of senior housing, it puts in place significant consumer protections for assisted living. Today, Governor Pataki and the Legislature have upheld a long tradition in New York of protecting its older citizens."

Rick Grimes, President/CEO of the Assisted Living Federation of America, said, "From a national perspective, passage of this assisted living reform law is hugely important. True resident choice - so central to the philosophy of assisted living - is being promoted as a result of this landmark legislation. ALFA applauds Governor Pataki and New York's lawmakers for their efforts and we are proud to have played a role in helping to achieve this outcome."

Lisa Newcomb, Executive Director of the Empire State Association of Adult Homes and Assisted Living Facilities, said, "We're proud that the reforms we fought so hard for are now law. The Governor and the Legislature should be commended for a thoughtful and comprehensive approach that protects consumers and ensures the future growth of this critical component of New York's long term care system."

The law establishes the Assisted Living Reform Act to fill gaps in adult residential services law that in some instances allowed facilities to operate without any licensure or state surveillance, and in other instances prevented facilities from appropriately expanding the range of services provided to their residents. The law essentially achieves two main objectives:

It requires certain adult residences that are currently unlicensed (known as 'look alike' facilities) to become licensed as Adult Care Facilities (ACFs) and therefore become subject to state regulation and oversight; and

It requires any residence that wishes to market itself as assisted living to seek an additional licensure as an Assisted Living Residence.

In addition, those operators who wish to provide a broader range of services, (known as 'aging in place' services) must obtain an Enhanced Assisted Living Certificate from the state Department of Health (DOH).
Moreover, those operators seeking to provide enhanced services to special needs residents, such as those with Alzheimer's or dementia, would have to obtain a Special Needs Certificate from the DOH.

The law also creates stiff new fines of up to $1,000 per violation per day for operators who fail to meet the new standards. An enforcement fund supported by fines and licensure fees will be used by the State to further strengthen surveillance and enforcement activities.

The law also provides strong consumer protections to seniors, including a requirement that assisted living residences use "plain language" contracts that fully disclose a residence's services, fees and policies. The legislation includes a "Bill of Rights" to ensure that residents retain the option of managing their personal and financial affairs in the homes. The DOH is also authorized to develop a consumer information guide to inform and assist consumers in the selection of assisted living residences.

To obtain either the Enhanced Assisted Living or Special Needs certificate, operators must submit a plan to the DOH demonstrating how they will safely and appropriately meet all of their residents' needs, and have policies in place to continually meet those needs as they change over time. The plan also must describe the specific services for each resident, the staffing levels, the education, training and work experience of the staff, and the details of any renovation or modification to the facility made by the operator.

State Health Commissioner Antonia C. Novello, M.D., M.P.H., Dr.P.H said, "Governor Pataki's years of leadership in health care and support of housing for New York's most vulnerable citizens are what brought these much needed assisted living reforms to New York State. This law will better ensure that our seniors receive the highest quality care and it provides them with yet another option to choose from in New York's comprehensive long-term care system."

State Office for the Aging (SOFA) Acting Director Neal Lane said, "The Governor championed a law that now provides us with clearly defined definitions and rules for assisted living in New York State. The law brings added protections to seniors in assisted living and helps expand the housing options available to seniors throughout the state."

An expert assisted living task force is also being established under the law to help address historical and emerging issues related to this population. The DOH and the SOFA will work closely with the task force to develop and implement recommendations to further improve safety and service provision.

Disposition:

SSL Committee Meeting: 2008AS
(  ) Include in 2008 Supplement
(  ) Reject

Comments/Note to staff:
Money Follows the Individual

This Act:

- Requires a nursing facility to refer a resident to the Department of Health and Mental Hygiene or its designee for assistance in obtaining home- and community-based services;
- Requires the Department or its designee to review quarterly assessments to identify individuals indicating a preference to live in the community; and
- Requires the Department or its designee to provide specified residents with information and assistance, including assistance in moving from a nursing facility to a community-based setting.

Submitted as:
Maryland
HB 478
Status: Enacted into law in 2003.

Disposition:

SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff:
26-28AS-30 Unnecessary Institutionalization of People Age 60 and Older

This Act directs the state department of aging to establish a program of services to prevent unnecessary institutionalization of people age 60 and older who need long term care or who are established as people who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements.

Submitted as:
Illinois
Public Act 093-0902
Status: Enacted into law in 2003.

Disposition:
SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff:
A Maryland legislative fiscal note describes Naturally Occurring Retirement Communities as “a defined geographic area or an identifiable residential community that has existed for at least 20 years and, as a result of natural demographic changes, has concentrated clusters of residents over the age of 60.”

This Act establishes a Naturally Occurring Retirement Community Demonstration Program within the Department of Aging. The program will award grants to “program participants” to provide services that help elderly residents in naturally occurring retirement communities. The stated purpose of the program is to assure elderly residents’ access to necessary services, prevent unnecessary hospital and nursing home stays, and increase private and charitable financial support for program grants to provide these services. This program is effective from October 1, 2002 through August 31, 2005, contingent upon the availability of federal funds.

The Department of Aging will set eligibility criteria for awarding grants in consultation with the Commission on Aging, the Interagency Committee on Aging Services, and representatives from housing and senior citizen groups from all areas of the State.

No more than 10 grants may be awarded in the first 12-month period. Grants may not exceed $150,000 for a project in any 12-month period and generally must be matched with an equal amount of funds, 25% of which must come from the grant applicant. The department may waive all or part of the matching requirements if a low-income naturally occurring retirement community cannot afford the match.

Submitted as
Maryland
SB 535
Status: Enacted into law in 2002.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act establishes increased regulatory oversight over the activities of home health agencies. It broadens jurisdiction of the state department of banking, insurance, and securities to include oversight over home health agencies undergoing a change in ownership and agencies seeking to modify the boundaries of the geographic regions within which they provide home health services. In addition, it provides a new statutory framework within which the department of aging and independent living monitors the programs and policies of home health agencies. For example, home health agencies are required to abide by minimum program standards, prepare a local community services plan, submit data related to access, cost, and quality issues, obtain the commissioner's approval of shared service agreements, establish a complaint process, and undergo a re-designation process every four years. As a whole, the Act is intended to provide state action immunity for actions that might otherwise be considered to be in violation of state or federal antitrust laws.

Submitted as:
Vermont
Act 57
Status: Enacted into law in 2005.

Disposition:

SSL Committee Meeting: 2008AS
( ) Include in 2008 Supplement
( ) Reject

Comments/Note to staff:
This Act directs the state department of elder affairs to establish minimum standards for certifying and monitoring elder group homes. The department may adopt by reference, with or without amendment, nationally recognized standards and rules for elder group homes. The standards and rules shall be formulated in consultation with the department of inspections and appeals and affected industry, professional, and consumer groups and shall be designed to accomplish the purposes of the Act. Such purposes shall include but not be limited to rules relating to:

- Provisions to ensure, to the greatest extent possible, the health, safety, well-being, and appropriate treatment of tenants;
- Requirements that elder group homes furnish the department of elder affairs and the department of inspections and appeals with specified information necessary to administer this Act. Under the Act, all information related to the provider application for an elder group home presented to either the department of inspections and appeals or the department of elder affairs shall be considered a public record;
- Standards for tenant evaluation or assessment, which may vary in accordance with the nature of the services provided or the status of the tenant, and
- Provisions for granting short-term waivers for tenants who exceed occupancy criteria.

The Act directs that each elder group home operating in the state shall be certified by the department of inspections and appeals. The owner or manager of a certified elder group home shall comply with the rules adopted by the department for an elder group home. A person, including a governmental unit, shall not represent an elder group home to the public as an elder group home or as a certified elder group home unless and until the program is certified pursuant to this Act.

Services provided by a certified elder group home may be provided directly by staff of the elder group home, by individuals contracting with the elder group home to provide services, or by individuals employed by the tenant or with whom the tenant contracts if the tenant agrees to assume the responsibility and risk of the employment or the contractual relationship.

If a tenant is terminally ill and has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, the elder group home and the Medicare-certified hospice program shall enter into a written agreement under which the hospice program retains professional management responsibility for those services.
This Act creates a Certified Retirement Community Program in the state tourism development cabinet to:

- Encourage retirees to live in the state;
- Identify issues of interest to retirees;
- Establish the mission of the program;
- Require coordination with specified state agencies;
- Establish requirements for communities to be certified as a state Certified Retirement Community;
- Specify the procedure for certification;
- Require a three-year commitment to the program and a long term plan;
- Define what assistance the tourism development cabinet shall provide to certified communities, and
- Provide that the program shall be implemented by the tourism development cabinet to the extent that appropriations from the general assembly are available.

Submitted as:
Kentucky
HB 40

Disposition:

SSL Committee Meeting: 2008AS
(   ) Include in 2008 Supplement
(   ) Reject

Comments/Note to staff: