2016

2015-2016 Mid-Session Legislative Summary

Assembly Committee on Aging and Long-Term Care

Assembly Committee on Aging and Long-Term Care

Assemblymember Cheryl R. Brown, Chair

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January, 2016

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Assembly Committee on Aging and Long-Term Care

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The following is a summary of legislation referred to, and heard by the Assembly Committee on Aging and Long-Term Care during the first year of the 2015-2016 Legislative Session. Informational Hearings conducted by the committee are listed at the end of this summary.

AB 74 (Calderon)

As introduced, AB 74 intended to increase inspections of facilities regulated by the Department of Social Services. Community Care Facilities, residential care facilities for the elderly, and child day care centers are currently subject to unannounced visits by the department at least once every 5 years. Some receive annual unannounced visits under specified circumstances, such as when a license is on probation, or to conduct annual unannounced visits to a randomized selection of 20% of the facilities that are not otherwise subject to annual inspection.

AB 74 instead makes every facility described above subject to an annual unannounced visit by the department on and after July 1, 2018. Until then, the bill revised the percentage of facilities subject to annual inspections to no less than 30% of facilities on or before July 1, 2016, and no less than 40% of those facilities on or before July 1, 2017.

According to the author, and testimony presented to the committee, increasing the frequency of licensing visits demonstrates that California is serious about addressing the inspection process for Community Care Facilities. More rigorous oversight would put California on par with the inspection schedules of other states. Currently, this state has a complaint-based oversight system that is reactive, instead of one that is proactive to prevent poor care, or to fix and stop deficient or sub-standard care before unfavorable consequences impact vulnerable residents. By at least having a licensing inspector present within community care facilities, "boots on the ground," once a year, the state would be able to be proactive, prevent deterioration in care, encourage better care, and no longer be operating under a complaints based system.

Ultimately, Senate amendments deleted provisions related to Community Care Facilities and residential care facilities for the elderly, before the measure was enrolled and submitted to the Governor.

Last Action: Vetoed on September 30, 2015.

> *GOVERNOR'S VETO MESSAGE:*
> *To the Members of the California State Assembly:*
>
> *I am returning Assembly Bill 74 without my signature. This bill would require the Department of Social Services to inspect licensed child care facilities once a year beginning January 1, 2019.*

Earlier this year, the 2015-16 Budget Act increased the frequency of inspections of licensed child care facilities to once every three years. Further increasing the frequency of these inspections may be a worthy goal, but the cost of this change should be considered in the budget process.

Sincerely,
Edmund G. Brown Jr.

AB 310 (Mathis)

This bill, as amended on March 26, 2015, directs the State Insurance Commissioner to annually study statutory requirements for long-term care products in California with those set forth in the Interstate Insurance Product Regulation Compact developed by the Interstate Insurance Product Regulation Commission, and marketed in New York, Texas, and Florida.

Last Action: AB 310 was not pursued by the author.

AB 332 (Calderon)

AB 332 was introduced to establish the Long Term Care Insurance Task Force within the Department of Insurance to examine the components necessary to design and implement a statewide long-term care (LTC) insurance program. Chaired by the Insurance Commissioner (or his or her designee), and composed of specified stakeholders and representatives of government agencies, this bill requires the task force to recommend options for establishing a long-term care insurance program, and to provide insight and comments on the respective degrees of feasibility for implementing such a plan, in a report submitted to the commissioner, the Governor, and the Legislature by July 1, 2017.

The author raised a critical concern about California's preparedness for the care needs, along with the economic, workforce, and policy implications, of a rapidly growing cohort of older, mostly non-working people with a high likelihood of disability living amongst a shrinking cohort of younger, working-age people. The "baby-boom" generation, those born between 1946 and 1964, began turning 65 in 2011. Today, roughly 13% (5,109,207 of 38,926,281) of California's population is age 65 or older, with about 1,000 people turning 65 each day, for about the next 14 years. By 2030, about 20% of the state's population will be age 65 or older (8,382,458 of 44,279,354). The 85+ population in California, the population most likely to require long-term care, services, and supports, currently stands at about 676,000 people, making up about 1.7%of the population, but will grow by 32% to over 993,000 by 2030, comprising of 2.7% of the total statewide population. The "baby-boom" population will begin turning 85 in 2031. The 85+ cohort will eventually grow to 5.4% of the total population by 2060 (2,851,396 of 52,693,383), according to the California Department of Finance's *"Report P-1: State and County Population Projections July 1, 2010-2060."* Continued medical and public health advances may contribute to even larger cohorts of the 65+ and 85+ populations.

A worker is considered to be at risk for serious economic hardship in old age if his or her retirement income falls under 200% of the poverty threshold for individuals. A study of retirement readiness published in 2011 by the UC Berkeley Center for Labor Research and

Education found that 47%of Californians are projected to have retirement incomes below 300% of the poverty level ($34,470 in 2013). Individuals who have not been able to save enough to provide adequate retirement income are unlikely to be able to support the added cost of LTC insurance premiums either before, or, especially, during retirement. Individuals with low retirement incomes who need long-term care services are most likely going spend-down their assets and rely on Medi-Cal to pay for those services.

The author notes that California does not have a reliable option for middle class seniors and persons with disabilities to obtain affordable long-term care. By liquidating and exhausting personal resources, seniors and persons with disabilities may access programs such as In-Home Supportive Services (IHSS), or skilled nursing facility care, for free, or with a share of cost if income levels demand. The other option, for those who have sufficient income, belongings and other financial resources, is to hire a private home, or home-health care aide – often exceeding $30 per hour depending on the level of, or length of time of the service.

Based on information presented during a recent Joint Informational Hearing on Financing Long-Term Care, baby-boomers are not like their parents. In comparison to their parents, baby-boomers, particularly women, have fewer savings and fewer assets than previous generations. With the recession and the massive loss of home equity fresh in people's minds, it should be no surprise that baby-boomers are less likely to own a home, more likely to have moved frequently, and thus, less tied to a neighborhood or community. Baby-boomers are generally less healthy, and afflicted with more obesity, diabetes, and heart diseases (i.e., high cholesterol, high blood pressure). Boomers are more likely to have been divorced, more likely to live alone, and more likely to have fewer, or no children.

The bill also requires the department to produce an actuarial report of the recommendations.

Last Action: Vetoed on October 11, 2015.

> *GOVERNOR'S VETO MESSAGE:*
> *To the Members of the California State Assembly:*
>
> *I am returning Assembly Bill 332 without my signature.*
>
> *This bill would establish a nine-member task force to explore the design and implementation of a statewide long-term care insurance program.*
>
> *Since the federal government and a number of private organizations have undertaken essentially the same task, I don't think that this bill is necessary. Moreover, I'm hesitant to start down a path that may lead to a large and potentially costly new mandate.*
>
> *Sincerely,*
> *Edmund G. Brown Jr.*

AB 348 (Brown)

AB 348, as amended, proposes a timeframe of 40 days for the Department of Public Health (DPH), Licensing and Certification (L&C) investigators to complete investigations of a complaint about

mistreatment, misconduct and abuse at a long-term health care facility within 90-days. A 30-day extension is also allowed. Sponsored by the California Advocates for Nursing Home Reform, AB 348 is a practical and workable solution to the California Department of Public Health's ongoing failure to make certain that complaints are adequately investigated to assure dignity, respect, and justice for those who have been mistreated, neglected or abused.

Testimony received by the Legislature in a Joint Oversight Hearing of the Assembly Committee on Aging and Long-Term Care and the Assembly Committee on Health indicates that DPH struggles to meet its work-load demands due to poor management and misplaced priorities. Testimony revealed thousands of complaints of mistreatment, misconduct and abuse are back-logged, and have languished for years with incomplete investigation, placing medically fragile and vulnerable adults in long-term health care facilities at risk of on-going harm, and tax-payers on the "hook" for paying for potentially poor and fraudulent care.

Budget action revised licensing fees to accommodate increased workforce at DPH in order to address consumer complaints, about 60% of the total number of reports about poor care, within a 90-day timeframe. Reports submitted by facilities and facility staff, are not subjected to this modestly rigorous standard (by historical standards), and investigations of such reports are back-logged, and the back-log continues to grow as of December 1, 2015.

Last Action: Held under submission in the Senate Committee on Appropriations.

AB 474 (Brown)

Originally introduced to address anti-retaliation, AB 474 was amended to address the clear and present crisis in poverty amongst older and disabled adults in California. Additional amendments to increase the Supplemental Security Income/State Supplementary Payment (SSI/SSP) monthly grants to individuals placed the bill outside the jurisdiction of the Assembly Committee on Aging and Long-Term Care, and AB 474 was re-referred to the Assembly Committee on Human Services, and the Assembly Committee on Budget.

Starting in 2009, policy makers, in an effort to close unprecedented budget deficits, reduced the state portion of the individual SSI/SSP grant from $233 to $156. At the time, the combined SSI/SSP monthly grant was equivalent to $907 month. The cut reduced the grant to $830 per month. During the subsequent budget years, the federal portion of the grant (SSI) has grown by $59 per month, to today's individual maximum grant of $889.

At a recent Informational Hearing of the Assembly Committee on Aging and Long-Term Care and the Assembly Committee on Human Services, testimony revealed that current SSI/SSP grants are inadequate to support safe housing, adequate food, and other needs. According to the Federal Poverty Level (FPL), an individual must earn at least $969 per month to be above the poverty line. At $889 per month, SSI/SSP provides only 90.7% of the minimum financial need to avoid "impoverishment."

Testimony also revealed that housing costs are exceeding most poverty-stricken people's ability to pay. Fair Market Rents (FMR) exceeds 50% of the current SSI/SSP grant in all 58 counties; in 15 counties, FMR exceeds 100% of the SSI/SSP grant.

AB 474 restores the cut from 2009, plus adds an additional $233 per month in order to stay ahead of the federal poverty line. By increasing the state portion of the SSI/SSP grant to $356, monthly grants will help California's most impoverished aged, blind and disabled adults manage California's unusually high costs of living.

Last Action: Held in Assembly Committee on Budget.

AB 563 (Lopez)

AB 563 requires the State Department of Developmental Services and the California Department of Aging, in consultation with certain stakeholders, to develop best practices for providing culturally competent services and supports to aging consumers with developmental and intellectual disabilities. The bill would require the State Department of Developmental Services to conduct a 2-year pilot program that implements those best practices in 3 regional centers that reflect the geographic diversity of California and, after the conclusion of the pilot program, by January 1, 2020, submit a report evaluating the pilot program, to the Legislature.

California's developmental system supports 21 regional centers, and 4 developmental centers. The California Department of Aging contracts with 33 Area Agencies on Aging. Geographically, both systems cover the entire state. Services and programs within both systems intersect more and more as families caring for developmental center clients become eligible for area agency on aging services due to age, and caregiving responsibilities. Developmental center clients, too, are living longer. Demographic trends show a prospect of greater interactions amongst the two systems more often in the future.

In an effort to assure efficient use of scarce public social service resources, the author is encouraging the promotion of the benefits of the two systems to reduce the likelihood of duplication. The author notes that the normal aging process for developmental system clients is often complicated by a lifetime of reduced mobility, poorer general health, medications, and surgeries. The more severe the developmental disability, the greater risk – and earlier onset – of the diseases commonly associated with aging.

As people with intellectual and developmental disabilities are living longer, it is very likely that service providers for both the community of people with intellectual and/or developmental disabilities (I/DD) and service providers for the growing population of older adults, have much to gain from each other as they strategize to promote similar core values related to self-determination, choice, independence, dignity, productivity, and inclusion in all aspects of community life for their corresponding populations. For instance, clients of both the developmental services system, and the patchwork of services

for older adults, is generally associated with a family unit (73% and 84% respectively) that provides care and protection, and are therefore inherent components of any discussion about their needs.

According to the Department of Developmental Services (DDS), "(T)he aging of parents or family members directly affects the demand for developmental services." For instance: "...an aging caregiver may require an increased level of services and supports to maintain their family member in the home. When these caregivers die, or are no longer able to support their loved ones, alternative living arrangements must be developed or located." The DDS notes that almost all forms of out-of-home care are more expensive than supporting a person in their own home, and their own data shows that the percentage of consumers living out of home increases as they age.

Researchers from the University of Colorado noted a decade ago: "...the mean age at death for persons with mental retardation was 66 years in 1993 - up from 19 years in the 1930s and 59 in the 1970s. The mean age at death for the general population in 1993 was 70 years. Longevity has also increased dramatically for persons with Down syndrome. Average age at death for persons with Down syndrome in the 1920s was 9 years; it rose to 31 in the 1960s and to 56 in 1993," which lead DDS to conclude that: "...consumers' increasing longevity means that services and supports will be provided, not only for a relatively longer period of time, but the needs will be greater or of higher intensity especially during the later years."

According to a 2012 study by the University of Illinois at Chicago and funded by the U.S. Administration on Developmental Disabilities, *"Bridging the Aging and Developmental Disabilities Service Networks, Challenges and Best Practices,"* people with developmental disabilities are aging at unprecedented rates and have unique health and service needs. Adults with developmental disabilities have a higher risk of developing chronic health conditions at younger ages than other adults, due to the confluence of biological factors related to syndromes and associated disabilities. The report highlights multiple initiatives which would benefit from collaborative relationships between those who advocate for the developmentally disabled, and those who advocate for the aged. Citing a time of dramatic policy change, the report recommends that agencies improve efficiency and coordination to better serve people with developmental disabilities and their families by better understanding the age-related needs and best practices in meeting those needs through research and evaluation.

Last Action: Pending a hearing in the Senate Committee on Human Services.

AB 643 (Nazarian)

Current law authorizes local law enforcement agencies to request the Department of the California Highway Patrol to activate a "Silver Alert" if the agency receives a report of a

missing person who is 65 years of age or older, developmentally disabled, or cognitively impaired. The alert may take the form of a "be-on-the-lookout (BOLO)" alert, an Emergency Digital Information Service message, or an electronic flyer, within a specified geographical area.

This bill authorizes the Silver Alert to be made by changeable message signs commonly seen on highways and freeways if a law enforcement agency determines that a vehicle may be involved in the missing person incident and specific vehicle identification data is available for public dissemination.

California has the largest number of seniors, age 65 or older, in the nation, currently at 5.1 million, and due to the Silver Tsunami, that number is expected to climb to 9 million by 2030. When a senior goes missing and has been determined by law enforcement to be in danger (for example, a senior with Alzheimer's disease who has wandered away from home), California uses a uniform alert system to help with recovery. It is estimated that over five million Americans suffer from Alzheimer's, and 60% of these persons are likely to wander from their homes. The Alzheimer's Foundation of America states that 50% of such wanderers risk illness, injury, or death if not located within 24 hours. Missing seniors must be found quickly because they have a 50% greater chance of serious injury or death when they've been missing over 24 hours, due to exposure and lack of much needed medications.

California supports 790 changeable message signs on major state highways subject to both federal and California policies. These regulations generally limit the use of changeable message signs to traffic operations and guidance information. Additionally, the signs are used for Amber Alerts and Blue Alerts.

Last Action: Chaptered by Secretary of State - Chapter 332, Statutes of 2015.

AB 664 (Dodd)

This bill requires, on or before January 1, 2017, the Department of Health Care Services (DHCS), the California Department of Social Services (CDSS), and the California Department of Aging (CDA) to evaluate and report to the Legislature (in consultation with a stakeholder workgroup), on outcomes and lessons of the existing Medi-Cal universal assessment tool (UAT) pilot. California provides home and community-based services (HCBS) to low-income Seniors and Persons with Disabilities (SPDs) to help them remain in their own homes and communities. Each of the three main Home and Community-Based Services (HCBS) programs; In-Home Supportive Services (IHSS); Community-Based Adult Services (CBAS); and, Multipurpose Senior Services Program (MSSP), perform their own eligibility determinations and service assessments, requiring those who receive services for more than one program to undergo multiple assessments that, in some cases, collect duplicative information. The author states that, in 2012, the Legislature recognized that separate eligibility determination and assessment processes create inefficiency in the administration of HCBS programs, and directed the state to develop a UAT to be pilot-tested in two to four counties with the goal of facilitating better care coordination, enhance consumer choices, reduce administrative inefficiencies, improve data analysis, and potentially create long-term fiscal

savings. However, the law establishing the UAT pilot test does not require the administration to conduct a formal evaluation. This bill is necessary to require a formal evaluation of the UAT pilot program, and to require the administration to report to the Legislature on the pilot's outcomes and lessons learned.

According to *"A Shattered System: Reforming Long-Term Care in California,"* a thorough assessment of the state's deficiencies in program and service design and delivery to meet the growing needs of an aging population published recently by the Senate Select Committee on Aging and Long Term Care, the most critical issue facing California's Long Term Care (LTC) system is the fragmentation of programs at the state, regional, and local levels. This fragmentation reflects decades of bureaucratic convenience, though it creates barriers to citizens accessing appropriate services, and drives, supports and promotes a lack of usable data to inform policy-makers struggling with critical decisions about scarce resources.

California lacks a strategic plan on long term services and supports that would set priorities for services for the future to maximize the use of finite resources. Despite the lack of a strategic plan, the state should take specific steps to position itself in a more favorable position to absorb the impact of a rapidly expanding population of individuals in need of long term services and supports.

California has an array of programs and services for individuals with disabilities. The programs are located in multiple agencies, use different delivery systems and challenge consumers, and family members, seeking to access services. Law makers, agency staff, and providers are routinely confounded by the results of a poor long-term [illegible] strategy. Multiple reports have concluded that California's long-term care services delivery system operates in different "silos" causing so-called "fragmentation," and a barrier to service between each fragment, or silo. As a consumer ages, and develops greater dependence on services, they are challenged by an assessment process that invades their privacy, seeking detailed information about their health, personal, and familial lives. The repetitive exposure of personal information serves to deter people from accessing services as the discomfort of disclosing deeply personal details about themselves to yet another stranger can aggravate and demoralize the client.

Universal assessment offers a single uniform process to connect services and corresponding data elements about service needs and preferences, while evaluating an individual consumer's needs in a consistent manner. According to one of the five principle recommendations within the Senate Select Committee on Aging and Long Term Care's report, the state should commit to universal assessment as a statewide initiative that can transform the existing system; it can be utilized not only for more accurate and efficient service delivery purposes, but also to support outcome analysis by gathering information that can be used as quality measures. At the state level, universal assessment data can help law makers and program planners simultaneously understand the needs of individual consumers, and consumers as a whole, support more strategic allocation of resources, and evaluate quality. A universal assessment tool will also assist the state to develop a data infrastructure with the capacity to collect and report integrated data from across programs to reduce redundancies and duplication while driving high quality program, fiscal and policy decisions.

Last Action: Chaptered by Secretary of State - Chapter 367, Statutes of 2015.

AB 1122 (Brown)

AB 1122 requires the State Department of Social Services, by January 1, 2017, to prominently display on the left side of its main Internet Web site, a link to the comprehensive list of all individuals, and associated information, who have been the subject of an administrative action since January 1, 1990, resulting in a license revocation or denial, or probation, or an individual exclusion or probation.

The list would be known as the Excluded Persons Administrative Action List (EPAAL) and would contain specified information, including the name of the individual and of the associated facility, and the status and effective date of each administrative action taken. The bill would require the list to be updated every 30 days. Additionally, the bill requires a licensee to provide written notice to a resident, the resident's responsible party, if any, and the local long-term care ombudsman, within 10 days of receiving a served notice from the department identifying an excluded person pursuant to an administrative action.

Last Action: AB 1122 was ultimately not pursued by the author due to existing reform implementation procedures at the Department of Social Services which may diminish the need for the bill.

AB 1136 (Steinorth)

Under existing law, (though inoperative due to a pending referendum petition) most stores are prohibited from providing a single-use carryout bag to a customer, though they may sell a reusable grocery bag or a recycled paper bag at the point of sale for not less than ten cents, though certain low-income people may receive a reusable grocery bag or recycled paper bag at no cost at the point of sale. AB 1136 would expand the group of customers who would be provided a reusable grocery bag or a recycled paper bag at no cost at the point of sale to include a customer who is 65 years of age or older and a customer who provides proof of current attendance at a California college or university.

Last Action: Pending hearing in the Assembly Committee on Natural Resources.

AB 1261 (Burke)

AB 1261 establishes the Community-Based Adult Services (CBAS) program as a Medi-Cal benefit and would require CBAS to be available as a covered service in contracts with managed health care plans. The bill specifies eligibility requirements for participation in the CBAS program, and requires that CBAS providers be licensed adult day health care (ADHC) centers and certified by the California Department of Aging as CBAS providers. The bill obligates CBAS providers to meet specified licensing requirements and to provide care in accordance with regulations.

For many years, Adult Day Health Care (ADHC) was a state plan optional benefit of the Medi-Cal program. The program was eliminated in 2011 as a result of the state budget crisis. A subsequent class action lawsuit, Esther Darling, et al. v. Toby Douglas, et al., challenged the elimination of

ADHC as a violation of the Supreme Court decision Olmstead v. L.C. The state settled the lawsuit, agreeing to replace ADHC services with a new program called CBAS effective April 1, 2012, to provide necessary medical and social services to individuals with intensive health care needs.

The Department of Health Care Services (DHCS) amended the "California Bridge to Reform" Section 1115 Waiver to include the new CBAS program, which was approved by the Centers for Medicare and Medicaid Services on March 30, 2012. Today, in counties that have implemented Medi-Cal managed care, CBAS is available as a managed care benefit. In counties that have not implemented Medi-Cal managed care, or for individuals that are exempt from enrollment in Medi-Cal managed care, CBAS is provided as a fee-for-service Medi-Cal benefit.

While the waiver covers services, state statutes have not been updated to reflect the new parameters of the CBAS program under the waiver. In addition, the transition to managed care coverage for CBAS has led to rate uncertainty. While the original settlement and draft waiver language included provisions to ensure that CBAS services provided through managed care plans were reimbursed at rates that are not less than Medi-Cal fee-for-service rates, the final waiver application and consequently the approved waiver requirements did not include the rate language.

Last Action: Vetoed on October 10, 2015.

GOVERNOR'S VETO MESSAGE:
To the Members of the California State Assembly:

I am returning the following six bills without my signature;

Assembly Bill 50
Assembly Bill 858
Assembly Bill 1162
Assembly Bill 1231
Assembly Bill 1261
Senate Bill 610

These bills unnecessarily codify certain existing health care benefits or require the expansion or development of new benefits and procedures in the Medi-Cal program.

Taken together, these bills would require new spending at a time when there is considerable uncertainty in the funding of this program. Until the fiscal outlook for Medi-Cal is stabilized, I cannot support any of these measures.

Sincerely,
Edmund G. Brown Jr.

AB 1518 (Committee on Aging and Long-Term Care)

AB 1518 authorizes the Department of Health Care Services to seek additional increases in the scope of the home-and community-based Nursing Facility/Acute Hospital (NF/AH) Waiver. The bill requires the department to apply for an additional 5,000 slots to be added in the 2016–17 fiscal year, beyond those currently authorized for the waiver.

"Medicaid waivers" allow states to deliver and pay for health care services while the federal government "waives" some of the usual Medicaid rules. For instance, Medicaid 1915(c) waivers allow states to provide long-term care services in home and community based settings, instead of licensed health care facilities. California's NF/AH waiver supports case management, habilitation, home respite, personal care services, community transition assistance, continuous nursing, and other supportive services, environmental accessibility adaptations, caregiver training for family members, private duty nursing such as home health care, and special case management for medically fragile and technology-dependent individuals.

Even as Medi-Cal long-term services and supports transition into managed care through the Coordinated Care Initiative, the NF/AH "waiver" provides comprehensive home and community-based alternative to nursing facility care for people who require services beyond those offered by such long-term care mainstays as In-Home Supportive Services (IHSS). While the NF/AH waiver has great potential to assist the state with meeting the directive of the *Olmstead* decision (which guarantees access to the least restrictive, most "integrated," or home-like settings for care, if not cost-prohibitive), California significantly limits the NF/AH waiver utilization, thus creating barriers to less-costly community living for eligible individuals. The current NF/AH waiver has an enrollment cap of 3,792 persons in 2015 and 3,964 in 2016, yet there are approximately 70,000 people on Medi-Cal in nursing homes on any given day, 25% of whom express an interest in leaving the facility and living in the community. Since waivers are applied for, and initiated by states, with Centers for Medicare and Medicaid Services (CMS) granting approval, AB 1518 directs the California Department of Health Care Services (DHCS) to seek permission to serve more than the 3,792 clients this year, and 3,964 next year.

Besides the limitation upon the number of participants, federal requirements for home and community-based waivers include cost-neutrality provisions. Federal cost-neutrality means that providing home and community-based waiver services to an individual, or a group of individuals, cannot cost the Medi-Cal program more than serving that individual, or that group of individuals, in an institutional setting. Currently, California applies a more rigorous standard that limits waiver participation and favors institution placements. Despite a federal option to utilize an "aggregate" cost-cap, California has opted instead to utilize an "individual" cost-cap, which does not permit the State to offset the waiver costs of higher need individuals with the lower costs individuals with less intensive needs. Interestingly, the waiver which supports developmentally disabled Californians home and community-based services utilizes an aggregate cost-cap with great success.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medi-Cal. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Children with the most significant medical needs can live at home with the support of home nursing. For Medi-Cal eligible children under age 21, EPSDT funds those services. Home nursing hours are calculated based on the appropriate institutional level of care equivalent.

At age 21, Medi-Cal recipients should transition from EPSDT to home nursing funded by the NF/AH Waiver, the Developmental Disabilities (DD) Waiver, or regional center services. Unless needs have changed, this transition should be seamless and services should not decrease.

However, some individuals have experienced a reduction in service because of the different way the NF/AH program operates, including lower caps on hours and more restrictive eligibility criteria.

Last Action: Ordered to Senate Inactive File at the request of Senator Mitchell.

AB 1526 (Assembly Committee on Aging and Long-Term Care)

Currently, there is no statewide or public source of accurate or reliable caregiver data. Prudent planning requires high-level, evidence based data such as that which is acquired by the Behavioral Risk Factor Surveillance Survey, under the appropriate jurisdiction of the California Department of Public Health, the state's primary source of population research and surveillance. In order to prepare the most efficient and effective infrastructure to support caregivers, the state must first determine the full scope and extent of caregiving in California.

AB 1526 seeks to extend the existing Behavioral Risk Factor Surveillance Survey conducted annually by the Department of Public Health on behalf of the Center for Disease Control (CDC), by 9 important questions which will begin to inform decision makers of specific needs of California's vast population of family caregivers.

The Behavioral Risk Factor Surveillance System (BRFSS) is a cross-sectional telephone survey that state health departments conduct monthly over landline and cellular telephones with a standardized questionnaire, and technical and methodological assistance from CDC. BRFSS is used to collect prevalence data among adult U.S. residents regarding their risk behaviors and preventive health practices that can affect their health status. Respondent data is forwarded to CDC to be aggregated for each state, returned with standard tabulations, and published at year's end by each state. In 2011, more than 500,000 interviews were conducted in the states, the District of Columbia, and participating U.S. territories and other geographic areas.

By collecting behavioral health risk data at the state and local level, BRFSS has become a powerful tool for targeting and building health promotion activities. As a result, BRFSS users have increasingly demanded more data and asked for more questions on the survey. Currently, there is a wide sponsorship of the BRFSS survey, including most divisions in the CDC National Center for Chronic Disease Prevention and Health Promotion; other CDC centers; and federal agencies, such as the Health Resources and Services Administration, Administration on Aging, Department of Veterans Affairs, and the Substance Abuse and Mental Health Services Administration.

Beginning in 2009, a special set of 10 questions have been available to examine various aspects of caregiving, referred to as the "Caregiver Module." The questions allow states to determine who is a caregiver; the relationship between the caregiver and the care recipient; the average hours of caregiving per week; the most difficult problem facing the caregiver; the age and gender of the care recipient; the types of assistance needed by the care recipient; the major health problem, long-term illness, or disability of the care recipient; the duration of caregiving; and whether the person has had more difficulty with thinking or remembering in the past year. The responses from the caregiver module are then paired with information from the main BRFSS questionnaire, which allow for additional information about the health and well-being of caregivers.

California is home to the largest number of seniors in the nation and their numbers are expanding at a pace unprecedented in history. The California Department of Finance's Demographic Research Unit estimates that California's 65+ population will have grown 43% between 2010 and 2020 (from 4.4 million to 6.35 million). By 2030 the 65+ population will reach nearly 9 million people. The ratio of 65+ people will grow from about one in ten people today, to one in five by 2040. Though women comprise roughly half of the general population, by age 65 their proportion increases to about 57%. By age 85, women outnumber men two-to-one.

Given the demographics confronting California, it comes as no surprise that most people will become a caregiver at some point during their lives. According to the Family Caregiver Alliance, "Caregivers are daughters, wives, husbands, sons, grandchildren, nieces, nephews, partners and friends. While some people receive care from paid caregivers, most rely on unpaid assistance from families, friends and neighbors." Caregivers support the needs of dependent individuals in a variety of ways, performing a range of tasks, including companionship, light house-keeping, meal preparation, and personal care tasks. More complex and sensitive tasks include money management, medication management, communicating with health professionals, and coordinating care. The Family Caregiver Alliance finds that many family members and friends do not consider such assistance and care "caregiving" - they are just doing what comes naturally to them: taking care of someone they love. But that care may be required for months or years, and may take an emotional, physical and financial toll on caregiving families.

The value of the services family caregivers provide for "free," when caring, was estimated to be $450 billion in 2009. The estimated value of unpaid care in California is $47 billion, accounting for over 3.8 billion hours of care at $12.17, the average caregiver wage in 2009. On the personal side, long term caregiving has significant financial consequences for caregivers, particularly for women. Informal caregivers personally lose about $659,139 over a lifetime: $25,494 in Social Security benefits; $67,202 in pension benefits; and $566,443 in forgone wages. Caregivers face the loss of income of the care recipient, loss of their own income if they reduce their work hours or leave their jobs, loss of employer-based medical benefits, shrinking of savings to pay caregiving costs, and a threat to their retirement income due to fewer contributions to pensions and other retirement vehicles.

Last Action: Vetoed on October 7, 2015.

GOVERNOR'S VETO MESSAGE:
To the Members of the California State Assembly:

I am returning Assembly Bill 1526 without my signature.

This bill would require the California Department of Public Health to include questions from the federal Centers for Disease Control and Prevention's Caregiver Module in its annual public health survey.

The department already has a process to determine the questions to be included in the survey each year. This law bypassed that process, and for that reason I am vetoing it.

Sincerely,
Edmund G. Brown Jr.

ACR 38 (Brown)

ACR 38 establishes the California Task Force on Family Caregiving to meet regularly and report to the Legislature, issues relative to the challenges faced by family caregivers and opportunities to improve caregiver support.

A 2012 report issued by the California Commission on Aging (CCoA) noted that the state faces serious caregiver challenges in today's economic climate. As budgets are cut at the state level, state policies are moving rapidly toward providing more services to frail elders in the home, according to the report, entitled *"Celebrating Caregiving in California."* The CCoA cautioned that policymakers must weigh the value of protecting the interest of family caregivers against the cost of institutionalization.

Families are the major provider of long-term care, but research has shown that caregiving exacts a heavy emotional, physical and financial toll. Many caregivers who work and provide care experience conflicts between their responsibilities. Twenty two percent of caregivers are assisting two individuals, while eight percent are caring for three or more. Almost half of all caregivers are over age 50, making them more vulnerable to a decline in their own health, and one-third describe their own health as fair to poor.

Women make up the majority of the unpaid caregiver workforce, often interrupting work careers to take on the burden of caring for a relative. Caregiving women face uncertain economic futures due to breaks from employment and the corresponding reductions to retirement plans and the Social Security system.

At a Joint Hearing of Assembly Committees on Aging and Long-Term Care and the Assembly Committee on Human Services in 2012, the committees heard testimony about caregiving in California. Given the demographics confronting California, it would come as no surprise that most people will become a caregiver at some point during their lives. According to the Family Caregiver Alliance, "...caregivers are daughters, wives, husbands, sons, grandchildren, nieces, nephews, partners and friends. While some people receive care from paid caregivers, most rely on unpaid assistance from families, friends and neighbors." The National Alliance for Caregiving and AARP report *"Caregiving in the United States, 2009,"* estimates 31.2% of households in the U.S. had at least one person who served as an unpaid family caregiver during the course of the year. At any one time, the report estimates 37.3 million people are providing care: 66% are women and 34% are men. The typical family caregiver is a 49 year-old woman caring for her widowed 69 year-old mother who does not live with her. She is married and employed. One point four million children ages 8 to 18 provide care for an adult relative; 72% are caring for a parent or grandparent; and 64% live in the same household as their care recipient. The same report estimates the number of caregivers in California at any given time is 4.0 million, with an estimated 5.88 million people serving as caregivers during the course of a year.

Last Action: Chaptered by Secretary of State – Resolution Chapter 200, Statutes of 2015.

ACR 49 (Weber)

According to the author, ACR 49 is a message to Legislative colleagues that the recent economic downturn had a disproportionate impact upon services relied upon by older people, and that their sacrifices are acknowledged and honored, as the state moves forward into a new era.

The aging of the population will bring about a nationwide wave of lifestyle changes, opening of new markets, and conclusions of others, shifts in real estate prices, potential increases in the cost of health, custodial, and long-term care, while placing heavy caregiving demands on a smaller number of younger family members and others available to provide support. The enormous burden of paying for services that are not planned for individually will be borne by a decreasing number of workers, which underscores the prudent objectives of legislators engaged in reforming today's systems of care. In a state where every 5th person is "silver-haired" as opposed to the one we are accustomed to today where every 9th or 10th person is silver-haired, every aspect of life is likely to be transformed. Housing demands may be turned upside down as elders rush to smaller, more compact living quarters. Transportation systems may be transformed, driverless cars being only one aspect of the conversion, as more drivers with eye-sight deficiencies flock to roads and highways. A larger cohort of vulnerable people will create opportunities for unscrupulous endeavors as well, and this will impact our justice system.

Last Action: Chaptered by Secretary of State – Resolution Chapter 63, Statutes of 2015.

AJR 8 (Brown)

AJR 8 recognizes the 50th Anniversary of the Older Americans Act (OAA) of 1965, affirms support thereof, and encourages the reauthorization of the Act with adequate funding to reflect the growing population that benefits from its services. According to the author, AJR 8 affirms the important role the OAA has played in the lives of older Americans throughout our nation and in our state. It also memorializes Congress to reauthorize the Act.

Congress passed the Older Americans Act in 1965 in response to concerns by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) to execute the newly created grant programs and to serve as the federal focal point on matters concerning older persons.

During the past 50 years, the OAA has been instrumental in contributing to the well-being of millions of older Americans. More importantly, the Act has improved the quality of life for some 4.5 million older Californians and has helped the neediest of our seniors; however, over the past ten years state funding for senior programs within the OAA has been slashed.

Since 2004, approximately $25 million has been cut, resulting in the elimination or dramatic reduction of critical community-based programs and services provided through the state's Area Agencies on Aging, including the Alzheimer's Day Care Resource Centers, Senior Companion,

Linkages, Respite Care, Brown Bag, Caregiver Resource Centers, and the Long-Term Care Ombudsman.

The state's older population is on the rise. The AoA projects that, in 2030, there will be approximately 72.1 million older persons in the United States, which is more than twice the number of seniors that were counted in 2000. People aged 65 or older represented 12.4% of the population in the year 2000 but are expected to be 19% of the population by 2030. According to the author, the Older Americans Act is needed more than ever in order to bring attention to senior issues and prepare for the "silver tsunami."

Last Action: Chaptered by Secretary of State - Resolution Chapter 53, Statutes of 2015.

SB 196 (Hancock)

This measure grants authority to Adult Protective Services (APS) program representatives to request protective orders for elder or dependent adults who have been physically abused, financially abused, or both. It also modernizes the definition of "abuse of an elder or dependent adult" to include financial abuse.

According to the author, SB 196 was developed to provide a narrow ability for county Adult Protective Services agencies to file a petition for a protective order when a referral for conservatorship has been made, but there is a need to petition the court for an order in the meantime to step-in and stop abuse in the most egregious cases while the conservatorship process, which can be lengthy, is decided.

Until a criminal case is filed, or a temporary conservatorship is in place, county agencies must rely on protective orders that are not adapted to the unique issues of adult abuse. Those protective orders include an Emergency Protective Order (EPO) or a restraining order (e.g. Temporary Restraining Order (TRO), etc.). However, those orders are mainly designed to prevent physical harm in domestic violence or physical abuse. And in the case of restraining orders, it presumes the victim has the ability to initiate the request.

Many elder abuse cases are not the result of domestic violence or physical abuse, but are instances of financial abuse. The victim is often unable to advocate on their behalf but has not yet been conserved. In these cases, time can be of the essence in protecting assets and stopping the abuse. Lack of access to financial information and financial protective intervention measures are among the biggest existing holes in the tools for APS agencies. Situations have occurred where bank accounts and even homes are stolen out from under incapacitated or hospitalized elders and dependent adults.

Cases of elder and dependent adult abuse are often complex. In many instances, it takes law enforcement officers and detectives several days or weeks to gather adequate evidence to file a case with the District Attorney's office or a prosecutor. While the process of charges being filed

and a criminal case initiated is being worked out, protective orders need to be available to prevent further abuse.

Last Action: Chaptered by Secretary of State - Resolution Chapter 285, Statutes of 2015.

SB 475 (Monning)

SB 475 forbids assessing a resident or his or her estate a monthly fee once a unit has been permanently vacated by the resident under certain conditions, and alters refund or repayment requirements of a lump sum entrance fee, under certain conditions.

According to the author, under current law, Continuing Care Retirement Community (CCRC) contracts that base the repayment of a resident's entrance fee upon the resale of the unit and not upon vacancy are unfair arrangements for consumers and there is little incentive to re-sell those units in a timely manner. In many cases the CCRC provider is able to take advantage of this type of contract, which can lead to seniors or their estates experiencing significant delays in the repayment of entrance fees. For example, a CCRC in Pacific Grove had not paid $530,600 to the estate of a resident who died more than 3 years prior because the refund was conditioned upon resale of the unit. SB 475 levels the playing field for the CCRC resident in a manner that will result in more timely repayments and adds an incentive for a CCRC to re-sell a unit in the form of interest on the unpaid remaining balance. Resident safeguards in the bill balance the need for steadfast repayment while ensuring the CCRC can remain fiscally solvent so the current residents are not adversely impacted.

Last Action: Vetoed on October 11, 2015.

GOVERNOR'S VETO MESSAGE:
To the Members of the California State Senate:

I am returning Senate Bill 475 without my signature.

This bill would change the way Continuing Care Retirement Communities repay a resident's entrance fee under the purchase contract, and establish interest penalties if repayment is not made and the unit has not been resold within a time certain. The bill would also establish a process at the Department of Social Services to investigate whether a good faith effort was made to resell the unit.

As California's aging population continues to grow, the need for elder care and housing options will also increase. One of the options is Continuing Care Retirement Communities, which provide retirees with housing and varying levels of care and services throughout the remainder of their lives.

While it is important that residents who buy into these communities be treated fairly, this bill would change the terms of contracts entered into by willing participants. It would also insert the department into the resolution of contract disputes. For these reasons, I am not signing this bill.

Sincerely,
Edmund G. Brown Jr.

SB 575 (Liu)

This measure establishes annual notifications, and an opportunity to designate alternative recipients of annual notifications, for long-term care insurance (LTCI) policy and certificate holders who are entitled to benefits after lapsing premium payment, or reducing premium payment.

The author introduced SB 575 to protect consumers and more specifically, the elderly and their caregivers. It requires long-term care (LTC) insurers to provide annual notification of the availability and amount of contingent benefits to the insured and, upon the insured's designation, at least one other person. Most consumers are eligible for contingent benefits if their long-term care insurance premium rate dramatically increases and they ae unable to continue making premium payments. Consumers stop paying premiums and "bank" the accrued benefits.

However, individuals who lapse their LTC policies do not receive periodic notification from the insurer that these benefits are available. Without notification, these individuals and their families can easily lose track of the existence of the benefits, especially if the insured suffers from cognitive impairment. These individuals and families likely end up paying for care or doing without when, in fact, benefits are available. This notification will give seniors and their loved ones a clearer understanding of benefits available to help finance and provide long term care.

Last Action: Chaptered by Secretary of State - Chapter 544, Statutes of 2015.

SB 613 (Allen)

SB 613 makes legislative findings describing the public costs of Alzheimer's disease (AD), and the public benefits of peer-reviewed, evidence-based research to inform Alzheimer's disease management. The bill also directs the Department of Public Health (DPH) to convene a "workgroup" to update the physician "Guidelines for Alzheimer's Disease Management *(April, 2008)*." Finally, the bill requires the Department to report those updates to the Legislature by March 1, 2017.

The author describes Alzheimer's disease as a public health crisis in California, but unlike other public health concerns there is no known cause, cure or prevention to reduce the impact on individuals, families, communities and our state's public programs such as Medi-Cal and In-Home Supportive Services (IHSS). The author cites a 42% increase in Alzheimer's in just the last decade. Experts agree that managing the course of Alzheimer's disease after a diagnosis is the best public health strategy we have available today. SB 613 proposes a statewide working group under the leadership of the California Department of Public Health, drawing on the existing resources and expertise of our state's 10 university-affiliated Alzheimer's Disease Centers. Our own experts will update the physician Guideline for Alzheimer's Disease Management to systematically improve quality of care, better manage complex patient populations, and lower public costs associated with Medi-Cal-funded hospital stays and nursing home placements. When someone in California learns they have Alzheimer's, there should be evidence-based, up to date, guidelines for physicians to follow to ensure the patients receive the care and support they need.

An estimated 550,000 Californians have AD. Research supported by the National Institute of Aging and the Alzheimer's Association states that the nation's growing elderly population will drive a 300% increase in the number of AD cases over the next four decades. The organization's estimate, is, that by 2050, there will be approximately 1.3 million Californians living with AD. Between 1990 and 2000, mortality rates of persons with AD increased 74%. AD was the 8th leading cause of death in the state in 2004, with a total of 6,962 deaths, a five% increase from the death rate in 2000. Of these deaths, nearly 70% were women, and over 99% occurred among residents 65 years of age and older. In California, Caucasians comprised 84.4% of the deaths, followed by Latinos with 6.9%, African Americans with 5.1% and Asians with 3.4%. Data shows the proportion of deaths increased with age and that over 61%of these deaths occurred among residents 85 years of age and older.

Last Action: Chaptered by Secretary of State – Chapter 577, Statutes of 2015.

2015 Informational/Oversight Hearings

PRESENTATION AND PANEL DISCUSSION
Assemblymember Cheryl R. Brown, Chair, Assembly Committee on Aging and Long-Term Care and the Public Policy Institute of California
SUBJECT: California's Aging Population
August 7, 2015
Capitol Event Center, Sacramento CA

INFORMATIONAL HEARING
Assembly Committee on Aging and Long-Term Care
Presentation by Dr. Dale Bredesen
SUBJECT: Cutting the Alzheimer's Incidence in Half in the State of California
May 5, 2015
State Capitol, Room 127

JOINT INFORMATIONAL HEARING
Assembly Committee on Aging and Long-Term Care, Senate Committee on Human Services and the Senate Select Committee on Aging and Long Term Care
SUBJECT: Planning and Preparing for the Looming Financial Risks for Long-Term Services and Supports: Who's Ready?
April 7, 2015
State Capitol, Room 444

JOINT OVERSIGHT HEARING
Assembly Committee on Aging and Long-Term Care and the Assembly Committee on Health
SUBJECT: California Department of Public Health: What progress is being made to improve nursing home oversight?
March 24, 2015
State Capitol, Room 4202

JOINT INFORMATIONAL HEARING
Assembly Committee on Aging and Long-Term Care and the Assembly Committee on Human Services
SUBJECT: Who Can Afford to Get Old? Senior Poverty in the Golden State
March 17, 2015
State Capitol, Room 444