Date of Hearing: June 21, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 281 (Dodd) – As Amended March 18, 2021

SENATE VOTE: 37-0

SUBJECT: Medi-Cal: California Community Transitions program.

SUMMARY: Extends the duration of the temporary state-only Money Follows the Person Rebalancing Demonstration (MFP) by requiring the Department of Health Care Services (DHCS) to cease enrollment January 1, 2028, instead of January 1, 2024 under existing law and by extending the sunset date of this state-only program from January 1, 2025 to January 1, 2030 (the MFP facilitates the transition of individuals from an inpatient facility who have resided in that setting for fewer than 60 days). Requires DHCS to implement and administer the California Community Transitions (CCT) program to help an eligible Medi-Cal beneficiary move to a qualified residence after the beneficiary has resided in an institutional health facility for a period of 60 days or longer. Establishes requirements for CCT beneficiary eligibility, lead agency functions, and program services. Requires DHCS to use federal funds made available through the MFP, authorized under federal Medicaid law to implement the CCT program. Requires DHCS to fund the CCT program and to administer the program in a manner that attempts to maximize federal financial participation if the MFP is not reauthorized, or if sufficient funds are not appropriated through the MFP. Contains an urgency clause to ensure that the provisions of this bill go into immediate effect upon enactment. Specifically, **this bill**:

1) Extends the sunset date of the temporary state-only MFP to facilitate the transition of individuals from an inpatient facility who have resided in that setting for fewer than 60 days by requiring DHCS to cease enrollment January 1, 2028, instead of January 1, 2024 under existing law. Extends the sunset date of this state-only program from January 1, 2025 to January 1, 2030.

2) Requires DHCS to implement and administer the CCT program to help an eligible Medi-Cal beneficiary move to a qualified residence after the beneficiary has resided in an institutional health facility for a period of 60 days or longer. Requires DHCS to administer this program consistent with the federal MFP, as authorized under federal Medicaid law.

3) Requires the CCT program to be made available to an "eligible individual" and makes participation in the CCT program voluntary for an eligible individual, defined as a Medi-Cal beneficiary who meets all of the following requirements:

    a) The beneficiary has resided continuously in an inpatient nursing facility for a minimum of 60 days and has received Medi-Cal benefits for services furnished by the facility for at least one day;
    b) The beneficiary has expressed interest in returning to the community and has been identified, referred by facility staff or family members, or self-referred to a CCT lead organization;
    c) The beneficiary has been deemed willing and eligible to transition to a qualified residence; and,

d) The beneficiary would continue to require the level of care provided by an inpatient facility, but for the provision of home- and community-based services after transferring to a qualified residence.

4) Requires the CCT program to target Medi-Cal beneficiaries who meet at least one of the following criteria:

   a) Individuals who are 65 years of age and older who have one or more functional, medical, or chronic conditions, including Alzheimer's disease and other dementias;
   b) Individuals who have an intellectual or developmental disability, or both, that manifested before 18 years of age;
   c) Individuals who are under 65 years of age who have at least one physical disability, including individuals who are HIV positive or have AIDS;
   d) Individuals who have been diagnosed with a chronic mental illness;
   e) Individuals who have experienced brain trauma resulting in functional challenges, but who do not have a mental illness; and,
   f) Individuals who are residents of nursing facilities with few or no care options outside the facility due to the individual's medical or behavioral conditions.

5) Defines a "qualified residence" for purposes of this bill as:

   a) A home owned or leased by an eligible Medi-Cal beneficiary or their family member;
   b) An apartment with sleeping, bathing, and cooking areas over which the beneficiary or the beneficiary's family has domain and control; or,
   c) Another residence in a community-based residential setting that meets the requirements of the federal home- and community-based settings rule, as determined by the DHCS, and consistent with the federal Medicaid law and regulatory requirements.

6) Requires CCT program services to be provided by a "lead organization," defined to mean an organization that is qualified to provide Medi-Cal home- and community-based services and meets any other requirements established by DHCS for the purposes of implementing this bill. Requires a lead organization to coordinate and ensure the delivery of all services necessary to implement this bill.

7) Requires lead organization functions to include all of the following:

   a) Ascertaining the eligibility and interest of a CCT-eligible beneficiary to return to a qualified residence by completing the following:
      i) Reviewing the beneficiary's medical records, including prior and current medical conditions, current treatments, functional impairments, cognitive and behavioral status, and ability to perform activities and instrumental activities of daily living;
      ii) Reviewing the beneficiary's family support; and,
      iii) Interviewing the beneficiary, and if applicable, their legal representatives, guardians, conservators, or anyone else authorized in writing by the beneficiary to speak with the CCT lead organization.
   b) Conducting an independent assessment to ascertain the beneficiary's functional ability and identify associated risks that must be addressed to ensure their health and welfare in the community;

c) Developing a person-centered initial CCT transition and care plan, as defined, and a final CCT transition and care plan, as defined; and,
d) Following up with the CCT program beneficiary to ensure home- and community-based long-term services and supports that are provided pursuant to the final CCT transition and care plan continue to meet the needs and preferences of the beneficiary in the community for 365 days after transition.

8) Requires CCT program services to include, but are not limited to, all of the following:

a) Transition coordination services, including enrollment, transition and care planning, and post-transition follow-up, as follows:

i) Requires enrollment to include, but is not limited to, interviewing a potential participant, conducting a clinical assessment, and developing a person-centered initial CCT transition and care plan, as defined;
ii) Requires transition and care planning to include, but is not limited to, developing a final CCT transition and care plan as defined, for setting up and securing proposed home- and community-based long-term services and supports; and,
iii) Requires post-transition follow-up to include, but is not limited to, services to ensure that long-term services and supports are in place and a participant's needs continue to be met by the services and supports available to them in the community.

b) Requires habilitation services, including coaching and life skills development, training for the individual to learn, improve, or retain adaptive, self-advocacy, and social skills. Requires habilitation services to support transitions and improve the beneficiary's quality of life in the community, and requires habilitation services to include both of the following:
i) Pre-transition habilitation services, which are required to be provided to a CCT program beneficiary while the beneficiary is still living in an inpatient facility. Requires the services to ensure the beneficiary is able to live safely in the community on the day of transition; and,
ii) Post-transition habilitation services, which are required to be provided to a CCT program beneficiary who has transitioned out of an inpatient facility and provides ongoing support to the beneficiary in the community.
c) Family and informal caregiver training;
d) Personal care services to assist a beneficiary to remain at home including, but not limited to, assistance with independent activities of daily living and adult companionship;
e) Home setup services, including, but not limited to, nonrecurring setup expenses for goods and services for a beneficiary who will be directly responsible for living expenses upon transition;
f) Home modification services, including environmental adaptions to a beneficiary's home, including, but not limited to, grab bar and ramp installation, modifications to existing doorways and bathrooms, and installation or removal of specialized electric and plumbing systems;
g) Vehicle adaption services, including, but not limited to, devices, controls, and training required to enable beneficiaries, their family members, and their caregivers to transport beneficiaries in their own vehicles; and,
h) Provision of assistive devices, which means adaptive equipment designed to accommodate a beneficiary's functional limitations and promote independence,

including, but not limited to, lift chairs, stair lifts, diabetic shoes, and adaptations to personal computers.

9) Makes Medi-Cal beneficiaries eligible to continue to receive program services once they have transitioned into a qualified residence for up to 365 days after the transition date.

10) Requires, if an eligible Medi-Cal beneficiary receiving CCT services is readmitted to an inpatient facility for a period of less than 30 days, the beneficiary to remain enrolled in the CCT program and eligible for services up to 365 days after the beneficiary was admitted into the facility.

11) Requires, if an eligible Medi-Cal beneficiary receiving CCT program services is readmitted to an inpatient facility for a period of more than 30 days, the beneficiary to complete a new clinical assessment and a new transition and care plan.

12) Permits, upon approval of the new plan, the beneficiary to reenroll in the program without meeting the CCT eligibility requirements.

13) Requires CCT program services to be provided by a CCT lead organization pursuant to a contract with DHCS.

14) Requires a lead organization that intends to enroll a beneficiary for CCT services to do all the following:

    a) Complete a clinical assessment of the beneficiary;
    b) Provide the beneficiary with a new enrollee information form; and,
    c) Work with the beneficiary to establish an initial CCT transition and care plan, which is required to be approved by DHCS before the beneficiary receives the services.

15) Requires the lead organization, before enrolling the beneficiary in the CCT program, to ensure the beneficiary meets the CCT eligibility requirements established in this bill.

16) Requires the completed clinical assessment, new enrollee information form, and final CCT transition and care plan to be submitted to DHCS.

17) Requires all CCT services provided pursuant to this bill to be person-centered and driven by the beneficiary receiving the services and supports.

18) Requires a clinical assessment using the consolidated Assisted Living Waiver (ALW)-CCT assessment tool to be performed by a registered nurse. Permits DHCS to exempt a lead organization from this requirement if a staff member of the lead organization meets competency criteria established by DHCS and is able to perform the assessment.

19) Requires DHCS to use federal funds made available through the MFP, authorized under federal Medicaid law to implement the CCT program.

20) Requires DHCS to fund the CCT program and to administer the program in a manner that attempts to maximize federal financial participation if the MFP is not reauthorized, or if sufficient funds are not appropriated through the MFP.

21) Permits DHCS to seek enhanced and complementary funding to increase participation in the CCT program.

22) Permits DHCS to implement, interpret, or make specific this bill by means of letters, provider bulletins, or similar instructions, without taking regulatory action.

EXISTING LAW:

1) Authorizes, under federal Medicaid law, states to develop home and community-based services (HCBS) for Medicaid participants who would otherwise require care in a nursing facility or hospital.

2) Authorizes the Secretary of the federal Department of Health and Human Services (DHHS) to undertake the MFP, to award competitive grants to states for demonstration projects that achieve the following:

   a) Increases use of HCBS, rather than institutional long-term care (LTC) services;
   b) Eliminates barriers that prevent or restrict the use of Medicaid funds for eligible Medicaid beneficiaries to receive appropriate long-term services in the settings of their choice;
   c) Increases the ability of states to ensure eligible Medicaid beneficiaries receive continued HCBS when they choose to transition from an institutional setting to a community setting; and,
   d) Ensures the state has procedures in place to provide quality assurance for and to continuously improve the quality of HCBS.

3) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage.

4) Establishes a schedule of benefits under the Medi-Cal program, including requiring:

   a) Home health care services to be covered benefits, subject to utilization controls; and,
   b) HCBS to be a covered Medi-Cal benefit to the extent FFP is available and services are approved by the DHHS. Limits covered benefits to the terms, conditions and duration of federal waivers.

5) Establishes, under state law, a temporary state program that requires DHCS to provide services consistent with the MFP for transitioning eligible individuals out of inpatient facilities who meet the federal definition of an "eligible individual" except that the individual is not required to have resided for at least 60 consecutive days in an inpatient facility.

6) Requires, commencing January 1, 2023, DHCS to cease to enroll beneficiaries in the state-only program in 5) above, and requires DHCS to cease providing services effective January 1, 2024, and sunsets and repeals the state-only program January 1, 2025.

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, the CCT is part of the federal demonstration project called MFP. Established in 2007, CCT made funding available to help low-income seniors and people with disabilities transition from skilled nursing facilities back into homes of their own. Surveys of nursing residents reveal that a majority of residents do not want to remain in a nursing facility, but thousands of Californians with disabilities are, not because they need the level of care, but simply because they lack the appropriate services and resources necessary to transition. The lack of services and support for this population results in individuals languishing in institutionalized care, at great public cost, when that level of care is neither necessary nor desired. CCT empowers those trapped in institutionalized settings, so they can return to a life of dignity and choice. Without these resources, people with disabilities who are low income simply cannot leave the nursing facility.

2) **BACKGROUND ON MFP AND CCT PROJECT.** In 2005, the federal Deficit Reduction Act (DRA) established the MFP, which authorized the Secretary of DHHS to award competitive grants to states for demonstration projects that increased the use of HCBS, rather than institutional care, for Medicaid beneficiaries.

   In January 2007, the federal Centers for Medicare & Medicaid Services (CMS) awarded DHCS a grant for the MFP called CCT. This grant is authorized under section 6071 of the federal DRA. The federal Patient Protection and Affordable Care Act extended the funding for MFP projects and further modified program requirements. The grant requires DHCS to develop and implement strategies for transitioning Medi-Cal members who have resided continuously in health care facilities for 90 days or longer back to a federally-qualified residence. Authorization and funding for MFT has been extended several times on a short-term basis.

   On December 27, 2020, President Trump signed the Consolidated Appropriations Act of 2021, which included an extension of the MFP grant through federal fiscal year (FFY) 2023 and appropriates $450 million for FFY 2022, and $450 million for FFY 2023. Under the Consolidated Appropriations Act of 2021, the CCT Program will receive grant funding to continue to transition eligible beneficiaries through September 2023 and up to four years after, as long as grant funding remains available. The grant requires DHCS to develop and implement strategies for transitioning Medi-Cal members who have resided continuously in health care facilities for 90 days or longer back to a federally-qualified residence. Under the Consolidated Appropriations Act of 2021, the 90 day minimum stay requirement was reduced to 60 days, effective January 26, 2021.

   In 2020, SB 214 (Dodd), Chapter 300, Statutes of 2020, establishes a state-only CCT program to provide services consistent with the MFP Program for transitioning eligible individuals out of an inpatient facility who do not meet the federal MFP Program requirement of having resided for at least 90 consecutive days in an inpatient facility. SB 214 sunsets January 1, 2025. AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, a health budget trailer bill in 2021, among other provisions, aligned state law with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The authority to enroll new beneficiaries in the state-only CCT program ends January 1, 2023, and the authority to provide CCT services to enrolled beneficiaries

expires January 1, 2024 with a state law sunset date of January 1, 2025.

The table below shows CCT enrollments and transitions for fiscal year (FY) 2019-2020, FY 2020-21, and FY 2021-2022 through June 8, 2022 for both the state-only program (SB 281) and the federally funded MFP/CCT. Starting in FY 2021-2022, the data identifies how many Medi-Cal beneficiaries were enrolled and transitioned through the CCT Project through state-funded (resided fewer than 60 days in an inpatient facility) and federally-funded (resided 60 or more days in an inpatient facility). Note, below is a snapshot of data entered into the CCT database, the number of enrollments and transitions will increase significantly as data entry is completed.

CCT Enrollments by Fiscal Year:

Fiscal Year	State-Funded, SB 281 – CCT Effective 7/27/21	Federally-Funded, MFP/CCT	Total
2019-2020	0	448	448
2020-2021	0	818	818
2021-2022 (partial thru 6/8/22)	112	441	553

CCT Transitions by Calendar Year:

Fiscal Year	State-Funded, AB 133 – CCT Effective 7/27/21	Federally-Funded, MFP/CCT	Total
2019-2020	0	202	202
2020-2021	0	422	422
2021-2022 (partial thru 6/8/22)	20	265	285

DHCS' 2022 May Medi-Cal Estimate assumes savings of $26.7 million total funds in 2021-22 ($14.4 million General Fund [GF]) and $34.4 million TF in 2022-23 ($19.4 million GF) from MFP. The savings estimate are a result of individuals moving from year-around nursing facility services to CCT services based on a full year cost of nursing facility services of $91,998 ($45,999 GF) in 2021-22 and $88,965 ($44,825 GF) in 2022-23, that 120 transitions in 2021-22 and 140 in 2022-23 are unsuccessful at a cost of $4,716 for six months in the federal MFP and six and 16 transitions are unsuccessful in the state-only program (at an annual cost of $1,509 GF), and that 587 individuals are successfully transitioned in 2022 (201 from the state-only program and 386 from the federal MFP program). The state and federal savings from transitioning individuals results from the lower cost $18,000 ($4,500 GF) annually in 2021-22 and 2022-23 of being in the state-only or federal MFP, instead of the full year cost ($91,998 in 2021-22 and $88,965 in 2022-23) of remaining in a nursing facility.

3) **CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CalAIM).** In addition to the CCT provisions, AB 133 also enacted the CalAIM changes to the Medi-Cal program.

CalAIM and AB 133 made multiple changes to the Medi-Cal program, including several that would impact Medi-Cal beneficiaries in a SNF. AB 133 required the benefits provided by Medi-Cal managed care (MCMC) plans be standardized. This includes, effective January 1, 2023, requiring institutional LTC services (SNF, pediatric/adult subacute care, intermediate care facilities [ICF] for individuals with developmental disabilities, disabled/ habilitative/ nursing services, specialized rehabilitation in a SNF or ICF), currently not within the scope of many MCMC plans to be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In 2016, federal Medicaid managed care regulations were changed to permit federal Medicaid matching funds to be provided to plans that provide services or settings that are "in lieu of" services (ILOS) or settings covered under the state's Medicaid program. These ILOS are provided as a substitute, or to avoid, other services such as a hospital or SNF admission, discharge delays or emergency department use. Under federal Medicaid regulation, ILOS are subject to the following:

a) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
b) The enrollee is not required by the plan to use the alternative service or setting;
c) The approved ILOS are authorized and identified in the plan contract, and will be offered to enrollees at the option of the plan; and,
d) The utilization and actual cost of ILOS is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

DHCS has proposed 15 benefits that MCMC plans could choose to offer as ILOS, which was also codified in AB 133. Included within the ILOS that plans could offer related to this bill are recuperative care or medical respite, respite, day habilitation programs, nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities, nursing facility transition to a home, personal care and homemaker services, and environmental accessibility adaptations or home modifications.

4) SUPPORT. This bill is jointly sponsored by East Bay Innovations and Disability Rights California (DRC), which write in support that this bill would ensure continuation of the successful CCT, which has assisted more than 3,500 individuals in moving out of a nursing home and into their own home or other community setting. DRC writes that the CCT has successfully demonstrated the State is able to accomplish three goals simultaneously: a) Medi-Cal beneficiaries living in skilled nursing institutions for longer than 60 days can be transitioned back into community living; b) California can comply with the *Olmstead* decision requiring the State to enable people with disabilities to live in the most integrated setting possible; and, c) the State can realize savings since community living is more cost effective for the State. Accordingly, DRC writes the average savings per participant per year average approximately $60,000, and that even if the program were funded entirely with GF it would still generate savings for the state. Moreover, beyond the savings CCT generates the program helps move people out of institutions and into their homes and communities. Significantly, of the CCT transitions, 83% remained in the community for at least a year.

East Bay Innovations, a CCT provider, writes that this bill will create permanent and stable

program authority and funding in California, thereby enabling CCT organizations to continue to successfully reintegrate individuals back into community settings from skilled nursing facilities and other hospital/institutional settings.

5) **RELATED LEGISLATION**. AB 2823 (Levine) increases the maximum dollar value of the "home upkeep allowance" (HUA) in the Medi-Cal program, which is money a Medi-Cal beneficiary in a LTC facility is allowed to keep for upkeep and maintenance of the beneficiary's home. Under AB 2823, the HUA would be based on the actual minimum cost of maintaining a resident's home, instead of the current $209 per month amount. Requires money that would have otherwise gone to the resident's share-of-cost in Medi-Cal to instead be applied to the HUA. Establishes a "transitional needs allowance" to cover the costs of securing a home for an individual if a LTC facility resident does not have a home, but intends to leave the facility and establish a home in the community. Includes within the costs eligible for funding from the transitional needs allowance (TNA) to include, but is not limited to, rent, security and utility deposits, accessibility modifications necessary to meet the needs of the individual, and essential furnishings. Requires the TNA to be set aside from the income that otherwise would be applied toward the resident's Medi-Cal share of cost for residing in the facility, caps the duration of the TNA deduction at no more than six months, and makes the TNA available only if a physician has certified that the resident is likely to return to the community. Requires moneys in the HUA to be considered an exempt asset for Medi-Cal eligibility purposes. Requires the Department of Health Care Services (DHCS) to take specified information and outreach activities related to the HUA and TNA. AB 2823 is in the Senate Appropriations Committee.

6) **PREVIOUS LEGISLATION**.

   a) SB 214 (Dodd), Chapter 300, Statutes of 2020, requires DHCS to provide services consistent with the MFP, until January 1, 2024, in order to facilitate transitioning individuals, who have resided less than 90 consecutive days in an inpatient facility, out of inpatient facilities.

   b) AB 50 (Kalra) of 2019 would have required DHCS to submit to the federal CMS a request for amendment of the ALW program with a phased in increase in the number of participants to 18,500 by March 1, 2023. Would have required at least 60% of the expanded ALWP participant population in each phase to be reserved for persons transitioning from an institutional setting, defined as a person having a stay of 20 or more consecutive days in a health facility. Would have required DHCS to increase the geographic availability of the program on a regional basis. Would have required DHCS to increase its provider reimbursement tiers to compensate for mandatory minimum wage increases that came into effect in 2007, 2008, 2014, and 2016, that were not reflected in the reimbursement tiers, and requires DHCS to continue to adjust the reimbursement tiers to compensate for future mandatory minimum wage increases. Would have required DHCS to establish requirements and procedures so that any person on the ALWP's waiting list each month is able to know their position on the waiting list and when they are likely to reach the top of the waiting list. AB 50 was held on the Senate Appropriations Committee suspense file.

   c) AB 1042 (Wood) would have increased the maximum dollar value of the HUA in the Medi-Cal program, which is money a Medi-Cal beneficiary in a LTC facility is allowed

for upkeep and maintenance of the home. Would have permitted a LTC resident who does not have a home but intends to leave the LTC and establish a home in the community to establish a Transitional Needs Fund (TNF) for the purpose of meeting the transitional costs of establishing a home. Would have required moneys in the HUA and TNF to be considered an exempt asset for Medi-Cal eligibility purposes. Would have required money that would have otherwise gone to the resident's share-of-cost in Medi-Cal to instead be applied to either the HUA or TNF. Would have required DHCS to take specified information and outreach activities related to the HUA and TNF. AB 1042 was held on the Senate Appropriations Committee suspense file.

7) POLICY QUESTIONS:

a) Extension of current state-only program sunset date. SB 214 (Dodd), Chapter 300, Statutes of 2020, requires DHCS to provide services consistent with the MFP Program, until January 1, 2024, in order to facilitate transitioning individuals, who have resided less than 90 consecutive days in an inpatient facility, out of inpatient facilities. AB 133 extended the sunset date an additional year to January 1, 2025 and shortened the duration of residence in an inpatient facility from 90 days to 60 days in response to a change in federal law. This bill would extend that sunset date an additional five years, until January 1, 2030. SB 214 was enacted in the context of COVID public health emergency and death and disability of residents of skilled nursing facilities and the transmission of the virus to a vulnerable at-risk population. It is unclear if the state will be in a similar situation with COVID over the next six years that would warrant a sunset date extension of that duration.

b) Establishment of a new state-only program if federal MFP funding ends. This bill requires DHCS to implement and administer the CCT program to help an eligible Medi-Cal beneficiary move to a qualified residence after the beneficiary has resided in an institutional health facility for a period of 60 days or longer, consistent with the federal MFP. Further, this bill would require DHCS to fund the CCT program and to administer the program in a manner that attempts to maximize federal financial participation if the MFP is not reauthorized, or if sufficient funds are not appropriated through the MFP, in effect creating a state-only program. DHCS indicates there are no proposals in the current year or budget year to change or eliminate the CCT program. DHCS indicates the federal MFP is currently authorized to continue through September 30, 2023, and unspent grant funding remains available for up to four years after, through September 30, 2027.

8) PROPOSED AMENDMENTS. Following discussions between the committee and the author's office, given the uncertainty of the duration of the COVID-19 public health emergency, this bill will be amended to shorten the date by which the state-only MFP program would cease to enroll new individuals to January 1, 2026 (instead of January 1, 2028 as this bill proposes), cease to provide services (to January 1, 2027 instead of January 1, 2029), and the program sunset date to January 1, 2028 (instead of January 1, 2030 as this bill proposes). In addition, this is a two-year bill that amends law that was amended by last year's health budget trailer bill. Amendments are needed to this bill to ensure the changes made by this bill are being made to what is now existing law.

REGISTERED SUPPORT / OPPOSITION:

Support

Disability Rights California (cosponsor)
East Bay Innovations (cosponsor)
AARP
Advisory Council on Aging
Association of California Caregiver Resource Centers
California Alliance for Retired Americans
California Association for Health Services At Home
California Association of Public Authorities for IHSS
California Commission on Aging
California Foundation for Independent Living Centers
California Hospital Association/California Association of Hospitals and Health Systems
California Long-term Care Ombudsman Association
California Advocates for Nursing Home Reform
Independent Living Center of Kern County
LeadingAge California
National Association of Social Workers, California Chapter
National Multiple Sclerosis Society
Solano County Board of Supervisors
Western Center on Law & Poverty, Inc.

Opposition

None on file.

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