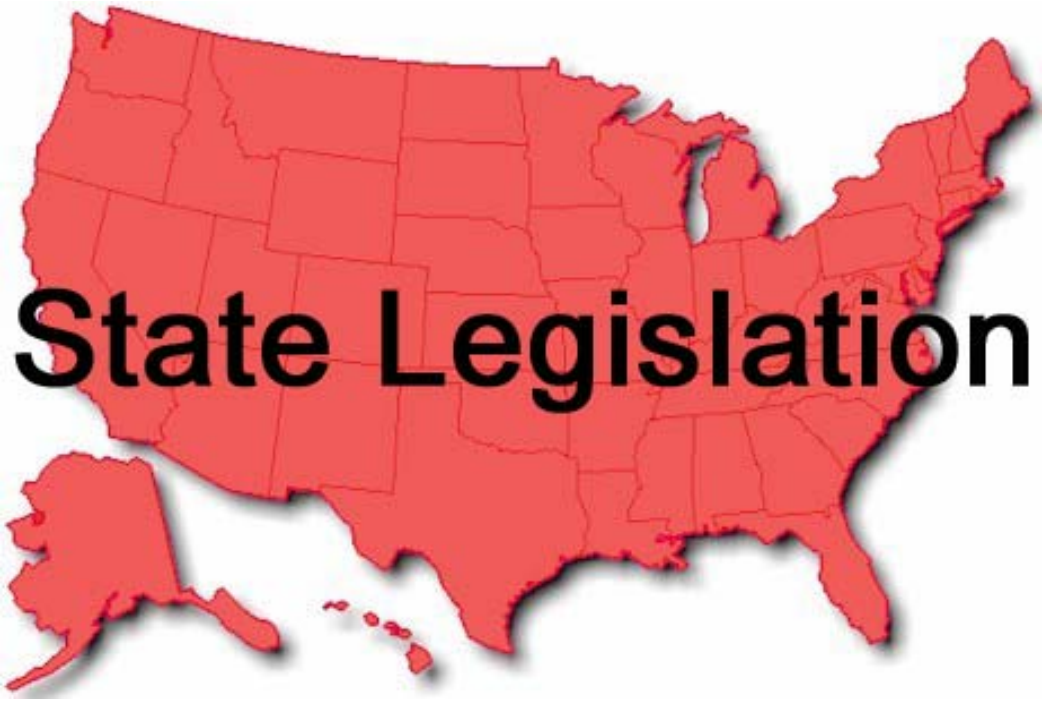
Summary of 2005-2006



and other public policy initiatives impacting individuals with traumatic brain injury and their families

compiled by the

National Association of State Head Injury Administrators

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The National Association of State Head Injury Administrators assists state government in promoting partnerships and building systems to meet the needs of individuals with brain injury and their families.

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Preface

This report is a summary of State legislation pertaining to traumatic brain injury that was signed into law or vetoed during the 2005 and 2006 State legislative sessions. These bills, and other State initiatives, have been reported in past issues of *State Watch* that is produced and distributed by the Traumatic Brain Injury (TBI) Technical Assistance Center (TAC) at the National Association of State Head Injury Administrators (NASHIA). This summary is organized by the main topic of the legislation, although some bills may carry more than one relevant topic. Obviously, there may be bills that passed that may be missed. However, the intent of this report is to provide an overview of trends in State public policy issues.

NASHIA was organized by State government employees with the intent of helping one another plan, implement, and administer public programs and services for individuals with brain injuries and their families. Other interested professionals, organizations, families and individuals with traumatic brain injury may also belong as associate members. To assist States and others to provide services and supports that reflect "best practices," NASHIA offers a national statewide meeting, regional meetings, Web site, listserv, State contacts, publications and materials for States and others to use. NASHIA tracks State and Federal public policy and legislation and produces updates and reports on these activities. NASHIA has also published the *Guide to State Government Brain Injury Policies, Funding and Services* (2003, 2005) and the 2007*Directory of State Government Brain Injury Contacts*.

The U.S. Department of Health and Human Services, Health Resources and Services Administration contracts with NASHIA to provide technical assistance to States and to State Protection and Advocacy Systems to expand State capacity for service delivery and advocacy services on behalf of individuals with traumatic brain injury and their families. The TBI TAC at NASHIA hosts learning community events on various topics, disseminates materials through a listserv and maintains a database featuring resources and other information through the Traumatic Brain Injury Collaboration Space (TBICS) that is accessed through NASHIA's Web site.

For further information on how to join NASHIA or to obtain information and materials visit the Web site at http://www.nashia.org.

Disclaimer

This report is not comprehensive. Submit omissions or share what brain injury-related legislation (or the status thereof) is being considered in your State for future editions by contacting Susan Vaughn, NASHIA's Director of Pubic Policy, at slvaughn@nashia.org or 573-636-6946.

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Overview

Since the 1980s, States have passed legislation with regard to prevention, registries, brain injury specific services and supports, as well as to expand other disability and health care programs to address the array of needs. This report is a summary of legislation passed (or vetoed) during the 2005-2006 sessions and other initiatives that impact service delivery for individuals with traumatic brain injury and their families. Many of these State efforts are in keeping with Federal legislation, funding, and litigation.

As the result of the TBI Act of 1996, as amended in 2000, the Health Resources and Services Administration (HRSA) Federal TBI Program has identified four core components necessary for service delivery: advisory board; State needs assessment process; State action plan, and lead State agency for organizing TBI services. Since 1997, HRSA has awarded competitive grants to States to establish these core components and to address identified gaps in service delivery. Some of the legislation that has passed reflects these efforts.

In addition to infrastructure, funding to pay for services is a critical piece for service delivery. State legislatures continue to introduce legislation to create or to increase revenue generated by designated fines, surcharges or fees associated with traffic-related offenses that are generally earmarked for TBI services, generally referred to as trust funds. Another strategy is to establish or expand home- and community-based services (HCBS) for individuals who are Medicaid eligible through HCBS waivers or State plan amendments. Some State legislatures appropriate general revenue (State dollars) for purposes of funding services or for increasing State match for additional Medicaid waiver services.

Congress and the Centers for Medicare and Medicaid (CMS) have passed legislation and proposed rules and regulations to contain and reduce Medicaid outlays. The Deficit Reduction Act (DRA) of 2005, signed into law February 8, 2006, reduces Medicaid and gives States flexibility to restructure their State Medicaid programs accordingly. The DRA made numerous changes to Medicaid relating to co-payments, benefit packages, money follows the person and home- and community-based services. As a result, States are reforming and changing their State Medicaid programs overall through legislation, State plan amendments and demonstration waivers.

Another factor that has influenced State and Federal policy is the 1999 Olmstead Decision (*Olmstead v. L.C. and E.W.),* which directs States to initiate efforts to offer individuals with disabilities community choices in lieu of institutional services. HCBS Waivers and money follows the person initiatives are strategies for directing funding for needed community-based services. Cash and counseling and self-directed care programs help individuals to obtain community-based services of choice. States are implementing these initiatives through legislation, appropriations, and Federal grants.

States continue to pass legislation designed to reduce injuries and fatalities related to motor vehicle crashes. As the result of these initiatives, States may be eligible for Federal funds from the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU), which authorizes the Federal surface transportation programs for highways, highway safety and transit. Additional fines and court costs associated with traffic violations are often imposed to generate funding for TBI services and supports. Several States have also passed legislation relating to education and training to help reduce injuries and fatalities associated with Shaken Baby Syndrome.

Bills Vetoed

Although State legislatures pass legislation, governors still have veto authority. On June 23, 2006, **Michigan** Governor Jennifer Granholm vetoed S.B. 297 that would have repealed the State's 37-year old all-rider motorcycle helmet law. The legislation would have removed the mandatory helmet requirement for all riders and passengers 21 years of age or older. "Repealing the requirement that motorcyclists wear helmets would be costly to all Michigan families," Governor Granholm wrote in her veto message.

On July 11, 2006, **Hawaii** Governor Linda Lingle vetoed S.B. 2727 to allow money from the neurotrauma special fund to be used for direct services that assist individuals with neurotraumatic injuries including, but not limited to, cognitive therapy, personal assistance, respite care, and day health programs. The bill also allowed moneys from the neurotrauma special fund to be appropriated to obtain Federal and private grant matching funds and create a "traumatic brain injury waiver." The legislature believed that State funds should be used to maximize the receipt of Federal funds whenever feasible.

However, in her veto message, Governor Lingle said the $1 million currently available in the trust fund is “insufficient to provide the direct services listed in this bill to the estimated number of persons that might need services per year in Hawaii.” The costs figures cited said that the average lifetime costs exceeds $4 million and, accordingly, the Governor said this would mean $57 million would be needed to cover 1,500 individuals hospitalized with TBI in Hawaii compared to $38,000 per year spent on individuals with developmental disabilities served by the Developmental Disabilities Division.

On August 16, 2006, **New York** Governor George Pataki vetoed A.B. 11650, which would have created the self-directed personal assistance services (PAS) program. The bill authorized the Commissioner of Health to establish a Cash and Counseling Program and to make any modifications necessary to the Medicaid State Plan pursuant to the Federal Deficit Reduction Act of 2005. New York received a grant from Robert Woods Johnson Foundation in the 1990s to implement a program offering Medicaid PAS consumers the choice of a cash benefit instead of agency-delivered care.

On September 29, 2006, **California** Governor Arnold Schwarzenegger vetoed A.B. 2108, a booster seat law, which would have required children under 8 years of age to be secured in a rear seat in an appropriate child passenger restraint system, and by requiring that a child who is 8 years of age or older, but less than 13 years of age, be secured in a rear seat in an appropriate child passenger restraint system or safety belt, thereby expanding the scope of an existing crime. The bill provided an exception from the child passenger restraint system requirement for a child who is under the age of 8 years, but who is 4 feet 9 inches tall or taller and who is properly restrained by a safety belt.

In his veto message Governor Schwarzenegger said that “simply increasing the maximum age requirement for children to be restrained by vehicle booster seats, as proposed by A.B. 2108, will do little to actually better protect our children. Parental responsibility is the key to protecting our children,” he said.

Bills Enacted

As the result of the TBI Act of 1996, as amended in 2000, the Health Resources and Services Administration (HRSA) Federal TBI Program has identified four core components necessary for service delivery: advisory board; State needs assessment process; State action plan and a designated lead State agency for organizing TBI services. These core components are also requirements for obtaining Federal funding. Many States have enacted legislation establishing advisory boards and designating lead agencies. During 2005-2006, a few State legislatures have enacted similar legislation.

Core Components:

Advisory Boards

Several State legislatures passed legislation establishing or changing advisory boards or councils. These include Maryland, Nevada, New Hampshire, Ohio, and Rhode Island.

Maryland Governor Robert L. Ehrlich, Jr., signed S.B. 395 on May 10, 2005, which establishes a State Traumatic Brain Injury Advisory Board. The legislation specifies the membership and duties of the advisory board; provides for staffing of the advisory board; requires the advisory board to meet at least once within a specified time period and requires the advisory board to elect a chair once every year. On May 26 Governor Ehrlich 2005 vetoed H. B. 309, as it was a duplicative bill.

On June 8, 2005, **Nevada** Governor Kenny Guinn signed S.B. 187 authorizing the members of the Advisory Committee on Traumatic Brain Injuries to receive the per diem allowance and travel expenses provided for State employees, effective July 1. On June 27, 2005, **Ohio** Governor Bob Taft signed legislation extending the sunset provision for the Ohio Brain Injury Advisory Committee. The bill extends ten State governmental entities sunset provision to 2010.

On May 25, 2006, **New Hampshire** Governor John Lynch signed S.B. 289, expanding advisory council membership and duties. The bill expands the number of members to 15 and provides for no-voting members representing various State agencies and programs. **Rhode Island** Governor Donald L. Carcieri signed H.B. 7546 on July 7, 2006, that changes the composition of the permanent advisory commission on traumatic brain injuries and identifies the type of expenditures that can be paid by the Traumatic Brain Injury Program.

(See the Appendix for the legislation passed by Maryland (p. 26), Nevada (p. 31), New Hampshire (p. 34), and Rhode Island (p. 37).)

Lead Agencies

State legislatures passed bills designating State agencies to be the lead agency for TBI. **Iowa** Governor Tom Vilsack signed legislation (H.F. 789) on April 29, 2005, designating the Department of Public Health as the lead agency for brain injury. The advisory council was already assigned to the department. On May 23 the governor signed H.B. 2772 (H.F. 2772), creating a brain injury services program in the division of the Iowa Department of Public Health in cooperation with counties and the Department of Human Services. Staff to the Advisory Council on Brain Injuries serves as the program administrator. The division duties shall include,

but are not limited to, serving as the fiscal agent and contract administrator for the program and providing program oversight. The council is to make recommendations to the department concerning the program's operation. The program is also to administer the TBI Home- and Community-Based Medicaid Waiver program.

On May 25, 2005, **Maine** Governor John Baldacci signed S.B. 239 designating the Department of Health and Human Services as the official State agency responsible for programs for persons with acquired brain injury. No later than January 16, 2006, the Commissioner of Health and Human Services shall make recommendations to the Joint Standing Committee on Health and Human Services on any changes necessary to ensure that a permanent, effective, and coordinated advisory capacity exists within the Department of Health and Human Services in order to advise the commissioner and the department on all matters pertaining to the administration and provision of programs and services for persons with acquired brain injury and their families. In making these recommendations, the commissioner shall ensure that the advisory process is broadly inclusive and representative of persons with acquired brain injury and their families and providers of services to persons with acquired brain injury.

Education:

In keeping with the Federal special education law, Individuals with Disabilities Education Act of 1990, as amended, several States continue to add TBI to their statutes or regulations as a disability eligible for special education services. On June 28, 2006, **Oregon** Governor Ted Kulongoski signed S.B. 167 which added traumatic brain injury to the list of disabilities eligible for special education services in State statute.

The Individuals with Disabilities Education Act (IDEA) of 1990 defines traumatic brain injury as"...an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psycho-social behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma." [34 Code of Federal Regulations §300.7(c)(12)]

Expand Service Capacity and Quality Assurance:

Group Home Pilot Program

In 2005 **Connecticut** Governor M. Jodi Rell signed H.B. 6646, which establishes statutorily the group home pilot program for older adults with acquired or traumatic brain injury. Community-based organizations are eligible to operate the residential program. The Commissioner of Public Health, in consultation with the Commissioner of Mental Health and Addiction Services, is to develop standards for operation of such residences and the training required of persons authorized under this section to administer medications in such residences. (See p. 41 in the Appendix for the legislation.)

Disability Services to Include TBI

Kentucky Governor Ernie Fletcher signed S.B. 47 on March 16, 2005, which adds brain injury to the list of disabilities eligible for services provided by the Department for Mental Health and Mental Retardation Services. The Department for Mental Health and Mental Retardation Services shall develop and administer programs for the prevention of mental illness, mental retardation, brain injury, and substance abuse disorders and develop and administer an array of services and support for the treatment, habilitation, and rehabilitation of persons who have a mental illness or emotional disability, or who have mental retardation, a brain injury, or a substance abuse disorder.

On March 11, 2005, **Utah** Governor Jon Huntsman, Jr., signed H.B. 80 that adds acquired brain injury as an eligible disability to receive services offered by the Division of Services for People with Disabilities. Brain injury is defined as "an acquired injury to the brain that is neurological in nature, including a cerebral vascular accident." To receive services individuals with acquired brain injury must meet other criteria such as the disability must be likely to continue indefinitely and results in a substantial functional limitation in three or more areas of major life activities: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; or economic self-sufficiency.

The following year **Utah** Governor Huntsman, Jr., signed H.B. 213, amending the definition of a disability within the Services for People with Disabilities chapter of the Utah Human Services Code as it relates to a brain injury. In lieu of major life activities defined for developmental disabilities as listed in the above paragraph, individuals with brain injury must have substantial limitations in three or more of the following areas: memory or cognition; activities of daily life; judgment and self-protection; control of emotions; communication; physical health or employment; and requires a combination or sequence of special interdisciplinary or generic care, treatment, or other services that (A) may continue throughout life; and (B) must be individually planned and coordinated. (See the Utah legislation on p. 42 in the Appendix.)

Special Nursing Home Rate for TBI Study

On May 26, 2006, **Connecticut** Governor M. Jodie Rell signed S.B. 703 requiring a study of State social services institutions and departments with respect to the expenditures by institutions and departments and the programs administered or services provided by such institutions and departments; an annual review to evaluate cost-effectiveness and benefits of the functions and activities and to assign priorities for their continued funding.

The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care, but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients.

Quality Assurance and Licensure Standards

On May 23, 2006, **Iowa** Governor Tom Vilsack signed H.B. 2780, addressing purposes and quality standards for services and other supports available for persons served by the Department of Human Services for Mental Health, Mental Retardation, Developmental Disabilities and Brain Injury. The legislation establishes basic financial eligibility standards and

addresses State and county financial responsibility for the cost of the services and other supports.

On June 20, 2005, **Louisiana** Governor Kathleen Babineaux Blanco signed H.B. 526 that establishes authority for the Department of Social Services to license and to regulate facilities that serve adults with brain injury. The legislation defines an adult brain injury facility as a publicly or privately owned facility that provides a rehabilitative treatment environment which serves four or more adults with a brain injury who are not related or services shall include personal assistance or supervision for a period of 24 hours continuously per day preparing individuals with traumatic brain injury for community integration.

This definition also applies to home or apartment settings that provide rehabilitative treatment and serves one to six adults with traumatic brain injury and also to facilities that provide outpatient rehabilitative treatment serving individuals with brain injury. The legislation sets the licensing fee for an adult brain injury facility at $800.

On March 25, 2005, **Virginia** Governor Mark Warner signed H.B. 2826 and H.B. 1237 which authorized the Department of Mental Health, Mental Retardation and Substance Abuse Services to license providers of services under the Medicaid Brain Injury Waiver and providers of residential services for persons with brain injury.

Arkansas Governor Mike Huckabee signed S.B. 945, the Adult and Long-term Care Facility Resident Maltreatment Act, April 6, 2005, providing a system for the Department of Human Services to report known or suspected adult and long-term care facility resident maltreatment and ensuring the screening, safety assessment and prompt investigation of reports of known or suspected maltreatment of residents in long-term care facilities, including post-acute head injury retraining and residential facilities.

Funding for TBI Services:

General Revenue

In 2006 the **Virginia** General Assembly appropriated $1.16 million in new annual funding for brain injury services. Expansion items included:

- $285,000 for Direct Case Management Services in Southwest Virginia (unserved/underserved)
- $150,000 to expand Case Management Services in Unserved/Underserved Regions of the Commonwealth
- $725,000 for Brain Injury Services in Unserved/Underserved Regions of the Commonwealth

Additionally, the General Assembly commissioned a committee to study brain injury in Virginia and to report on the extent of brain injury, the availability of appropriate services, the cost and array of treatments available and how other States have approached brain injury services. Legislators also included language requiring the Department of Rehabilitative Services to consider the recommendations of the Virginia Brain Injury Council in future funding allocations.

During the 2006 legislative session, the **Missouri** General Assembly appropriated $765,000 in additional general revenue for Fiscal Year 2007 (beginning July 1, 2006). This appropriation

increase was due, in part, to the legislature eliminating Medicaid State Plan optional services, including Comprehensive Day Rehabilitation Services for people with TBI, in 2005.

Medicaid Home- and Community-Based Services

Creates TBI HCBS Waiver

On April 6, 2005, **New Mexico** Governor Bill Richardson signed H.B. 318 which authorizes a Medicaid home- and community-based services (HCBS) waiver program for individuals with brain injuries with emphasis on long-term disability services. The legislation appropriated two million dollars ($2,000,000) from the general fund to the Aging and Long-term Services Department for expenditure in Fiscal Year 2005 and 2006, in cooperation with the Human Services Department. (See the legislation in the Appendix on p. 60.)

Similarly, **Montana** Governor Judy Martz signed S.B. 127 on April 21, 2005. This legislation authorized the Department of Public Health and Human Services to apply for a Federal Medicaid waiver that would expand HCBS to persons with disabilities, including individuals with brain injury 18 years of age and older, who are in need of habilitative and other specialized and supportive services to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations. Waiver programs may serve combinations of populations and subsets of populations that are appropriate for a particular program of services. S.B. 127 implements certain recommendations of the Montana Public Health Redesign Project regarding Medicaid HCBS. (See the legislation in the Appendix on p. 61.)

Expands Waiver Services

On June 14, 2005, **Iowa** Governor Tom Vilsack signed legislation (H.F. 825), which appropriated a $6 million increase to the Department of Human Services to eliminate all Medicaid waiver waiting lists. The funding was targeted for services to almost 2,500 Iowans who are ill or Iowans with disabilities. Four waivers, including the Brain Injury Home- and Community-Based Waiver, the AIDs waiver, Mental Retardation Waiver for State Cases, Ill and Handicapped Waiver and Physical Disability Waiver had waiting lists. Two days later, on June 16, Governor Vilsack signed another appropriations bill (H.F. 882), which called for distribution of funds to counties for county coverage of services to adult persons with brain injury.

New Hampshire Governor John Lynch approved the budget for the Department of Health and Human Services June 30, 2005. The budget provides for an increase of $617,035 for Fiscal Year (FY) 2006 and $1,262,446 for FY 2007 for services provided by the Acquired Brain Injury Home- and Community-Based Medicaid Waiver. For 2007 the amount includes $617,035 for the annualization of new services developed in 2006, and $645,411 to develop new services for FY'07 in order to provide services to individuals currently on the waiting list. The appropriations bill also includes a 2.3 percent inflation rate increase for salaries of direct care staff. (The Governor's biennium budget for State FY 2006 and 2007 was passed by the legislature on June 29, 2005.)

Mississippi Governor Haley Barbour signed S.B. 2053B, the appropriations bill for the Department of Mental Health, on June 20, 2005. The bill authorized the department to provide home- and community-based treatment and institutional treatment to not more than ten (10) persons at any given time who, on or after reaching their twenty-first birthday (age 21), suffered a severe brain injury and whose condition as a result of that brain injury would have resulted in their classification as developmentally disabled if such injury had occurred prior to their twenty-first birthday.

On May 17, 2005, **Connecticut** Governor M. Jodi Rell signed S.B. 1157, which allows the Commissioner of Social Services to amend the Medicaid home- and community-based service waivers serving persons with acquired brain injury and persons with mental retardation to include persons eligible for or receiving medical assistance under the Medicaid for Employed Disabled (MED) to participate in these waiver programs.

The Medicaid for the Employed Disabled program was authorized by The Ticket to Work and Work Incentives Improvement Act of 1999. Its implementation in Connecticut is mandated under Public Act 00-213 Work Incentives for Persons with Disabilities. The program allows persons with a disability to engage in employment without risking eligibility for needed medical services through the Medicaid program. The program also allows certain individuals to keep other necessary services needed to remain employed. In general, an employed person with a disability who is eligible can qualify for Medicaid without the use of spend down while earning income in excess of traditional income limits. S.B. 1157 was effective as of July 1, 2005.

Trust Fund Increase

Tennessee Governor Phil Bredesen signed H.B. 3256 on May 26, 2006, which imposes an additional fine of $15.00 to be deposited in the brain injury fund by drivers who leave the scene of an accident resulting in personal injury or death.

Medicaid State Plan Changes and Reform:

Addition of TBI Representation to Medicaid Advisory Committee

On May 16, 2006, **Maryland** Governor Robert L. Ehrlich signed H.B. 1330 that adds individuals with brain injuries to the membership of the Maryland Medicaid Advisory Committee. The bill requires the Secretary of Health and Mental Hygiene to seek recommendations from certain individuals and groups when selecting consumer representatives to the Committee. The Maryland Medicaid Advisory Committee improves and maintains the quality of the HealthChoice Program by assisting the Department of Health and Mental Hygiene. HealthChoice is the name of the Maryland's statewide mandatory managed care program which began in 1997.

Medicaid Downsizing

In 2005 **Missouri** Governor Matt Blunt signed legislature that tightened eligibility requirements for the State Medicaid program and eliminated "optional services" for adults who are Medicaid eligible, including the comprehensive day rehabilitation program for individuals with traumatic brain injury. The legislation eliminated coverage for the elderly or people with disabilities whose income exceeds 75 percent of the poverty rate; the Medicaid Buy-In program for individuals with disabilities who work at least an hour a month; and a special program that covers unemployable people and many who were awaiting Federal disability determinations.

The legislation requires premiums to be paid by parents who make at least 150 percent of poverty to enroll children in the Children's Health Insurance Program (SCHIP); triggers annual reviews of Medicaid recipients' eligibility and drops coverage for those who fail to submit wage stubs or other information verifying their incomes.* Furthermore, the legislation repealed optional services for most adults, including dental and optical care, podiatry, hearing aids, artificial limbs, wheelchairs and hospice care.** The legislation tightens the program that aids people with disabilities in their homes so that family members who serve as caregivers cannot be paid for normal household tasks such as fixing meals and doing laundry; and requires the

State to review whether Medicaid applicants have invested in annuities in the past five years to shield assets in order for the State to pay for nursing home care.

The bill also allows the State to charge co-payments ranging from 50 cents to $3.00, depending on the cost of the service, for services other than mental health and personal care and ends subsidies for parents who adopt foster children if parents earn more than twice the poverty rate. This act also moves the self-directed personal care assistance program for persons with physical and cognitive disabilities from the Department of Elementary and Secondary Education, Division of Vocational Rehabilitation to the Department of Health and Senior Services.

The legislation created a 12-person Medicaid Reform Commission to study and review the current Medicaid program and make recommendations to the General Assembly on reforming, redesigning, and restructuring a new innovative State Medicaid system to replace the current State Medicaid system by January 1, 2006.

*** A Federal court ordered Missouri to expand advance notice and hearing rights before terminating children from the SCHIP.**

**** On March 2, 2007, a Federal district court ordered Missouri to cease enforcement of the emergency Medicaid regulation that reduced durable medical equipment (DME) availability for most of the State's categorically needy Medicaid beneficiaries. The court issued a permanent injunction requiring the State to amend its current DME program to comply with Medicaid's reasonable-standards requirement. Seven Medicaid recipients with disabilities and ten public advocacy groups filed the lawsuit in August 2005, claiming the emergency regulation precluded them from Medicaid coverage for such DME as orthotics, catheters, hospital beds, bed rails, lifts and repair items. The regulations did maintain full DME coverage for categorically needy blind recipients. The Missouri General Assembly passed legislation on May 18, 2007, requiring coverage for "prescribed medically necessary durable medical equipment." The legislature also appropriated funding for Fiscal Year 2008 to pay for DME.**

Extends Eligibility/Authorizes Managed Care

In **Rhode Island** the legislature passed H.B. 5734, Health Care for Elderly and Disabled Residents Act, which became law on July 19, 2005, without the Governor's signature. The legislation amends the State Medicaid Plan to extend eligibility for categorically needy medical assistance coverage as permitted to individuals who are sixty-five (65) years or older and to individuals with disabilities. The legislation also adds "persons with cognitive disabilities, such as brain injuries," as being eligible for several State plan services including community residence, day treatment program, and habilitation services.

H.B. 5734 also authorizes the Department of Human Services to plan and implement a system of health care delivery through a voluntary managed care health system in order to ensure that individuals with disabilities have access to quality and affordable health care. The department is authorized to obtain any approval and/or waiver necessary to implement the voluntary managed health care delivery system. The department is also to submit a report to the Permanent Joint Committee on Healthcare Oversight no later than April 1, 2006, that proposes an implementation plan, projected program costs, and savings.

The legislation also authorizes the Department of Mental Health, Retardation and Hospitals to license residential and other support programs designed specifically for persons with "cognitive disabilities, such as brain injury," using the same standards as for programs serving persons with developmental disabilities.

Medicaid Reform

On June 3, 2005, **Florida** Governor Jeb Bush signed S.B. 838 allowing the State to submit a Section 1115 Medicaid Demonstration Waiver proposal to the Centers for Medicare and Medicaid (CMS) to implement Medicaid reforms on a pilot basis involving two counties, before going statewide. The legislation gives the State agency the authority to contract with HMO and non-HMO entities to serve Medicaid recipients in a capitated arrangement. While no Medicaid-eligible populations are to be excluded, the bill does direct the State Medicaid agency to develop special "service delivery alternatives" to meet the specific needs of certain disability groups (e.g., children with chronic medical conditions, Medicaid-eligible children in foster care, and persons with developmental disabilities).

S. B. 838 allows Provider Service Networks to be paid fee-for-service initially then phase-in financial risk (capitation) over a three-year period. The bill provides for the Florida Agency for Health Care (Medicaid agency) to contract with a vendor to monitor and evaluate the practices and patterns of Medicaid providers; authorizes the agency to competitively bid for single-source providers for certain services; provides for a prescription-drug-management system, allowing dispensing practitioners to participate in Medicaid; and addresses funding mechanisms for hospitals and for Medicaid buy-in programs.

The law requires the Florida Agency for Health Care, in partnership with the Department of Elderly Affairs, to develop an integrated, fixed-payment delivery system for Medicaid recipients age 60 and older. Among other provisions, it also requires that the Medicaid agency develop a plan to expand disease-management programs; develop an in-home, all-inclusive program of services for Medicaid children with life-threatening illnesses; authorizes the agency to pay for emergency mental health services provided through licensed crisis stabilization centers; and to develop a pilot program for capitated managed care networks to deliver Medicaid health care services for all eligible Medicaid recipients in Medicaid fee-for-service or the MediPass program.

Individuals who are 60 years of age or older and enrolled in the Developmental Disabilities HCB Waiver Program, the Family and Supported-Living Waiver Program, the Project AIDS Care Waiver Program, the Traumatic Brain Injury and Spinal Cord Injury Waiver Program, the Consumer-Directed Care Waiver Program, and the program of All-Inclusive Care for the Elderly Program, and residents of institutional care facilities for individuals with developmental disabilities are to be excluded from the integrated system.

The law required the agency to conduct a study of Medicaid buy-in programs to determine if these programs can be created in the State without expanding the overall Medicaid program budget or if the Medically Needy program can be changed into a Medicaid buy-in program.

CMS subsequently approved the Florida 1115 Medicaid Demonstration Waiver on October 19, 2005, and the Florida legislature granted approval to implement the waiver on December 8, 2005. The Florida Medicaid Reform focuses on moving a greater proportion of the State's Medicaid population into managed care environments. With the support of Choice Counselors, Medicaid beneficiaries are to take a more active role in their health care and have the flexibility to choose managed care plans and benefit packages that best suit their needs. Florida initially

implemented the demonstration in Broward and Duvall Counties to be followed by implementation in Baker, Clay, and Nassau Counties by July 2007.

In May, 2005, **Iowa** Governor Tom Vilsack signed a comprehensive bill (H.F. 841) into law that provides for Medicaid reform and includes a new program, called Iowacare. Iowacare replaces the Indigent Care Program, and is to cover approximately 30,000 adults under 200 percent of the Federal Poverty Level (FPL). The program is a capped, non-entitlement program and has a smaller benefit package than the traditional Medicaid program. The program also limits the provider network. The legislation requires Federal financial participation as a pre-condition to the Medicaid expansion.

House File 841 allows the State to:

- limit benefits under the Iowacare program to inpatient, outpatient, and physician services,
- limit enrollment, eligibility, services, and the provider network, and
- requires enrollees to pay a monthly premium on a sliding-fee scale, not to exceed 5 percent of annual income.

The legislation also allows the State to adopt higher level-of-care criteria for admission to nursing homes than for home- and community-based services (HCBS), with the intent to encourage greater access to HCBS. (Federal Medicaid policy requires that applicants for HCBS demonstrate that the severity of their condition puts them at risk for nursing home care.) Decoupling the criteria for nursing home care and HCBS should make it easier for Iowans to access HCBS.

CMS approved the State's 1115 Medicaid demonstration waiver applications in June 2005, allowing the program to begin on July 1, 2005.

1115 Medicaid Demonstration Waivers

Other States that have submitted 1115 Medicaid waivers include: **Arkansas** (2006), known as the Arkansas Safety Net Benefit Program designed to expand coverage to up to 50,000 uninsured adults over five years; **Hawaii** (2006), to extend coverage under the State's Quest Program; **Kentucky** (2006) to provide tailored benefit packages to four categories of beneficiaries; **Oklahoma** (2005) to implement the Employer/Employee Partnership for Insurance Coverage (O-EPIC) to address the State's high rate of uninsured persons; **Vermont** to implement the "Vermont Health Access Program (VHAP), and **West Virginia**. **Idaho** submitted a State Plan Amendment (2006) to target specific package of benefits to specific categories of enrollees—resulting in different benefits for children, people with disabilities, and dual-eligible beneficiaries.

Idaho's Benchmark Basic plan is to serve healthy children and adults and to offer most of the traditional Medicaid benefits, except long-term care, organ transplants, and intensive mental health treatment. Children under 19 years old will continue to receive benefits through the Early, Periodic Screening, Diagnostic and Treatment (EPSDT) requirements of Medicaid.

Elderly and disabled beneficiaries are to receive care in the Enhanced Benchmark plan. This plan will cover all traditional Medicaid benefits including long-term or institutional care. Beneficiaries enrolled in the Benchmark Basic plan needing additional benefits will be transferred to the Enhanced Plan. Dual eligibles will be enrolled in the Coordinated Benchmark

plan, which will include all the benefits of the State's traditional Medicaid program. Dual eligibles participating in this program will be required to enroll in the Medicare outpatient coverage plan (Part B) and the new Medicare prescription drug benefit (Part D). Beneficiaries will be allowed to opt out of the new benchmark benefits at any time and return to regular Medicaid, according to HHS.

In **Kentucky**, the KyHealth Choices Waiver specifies the following six components necessary to achieve its goals:

- **Targeted Benefits**. KyHealth Choices provides tailored benefit packages to four categories of beneficiaries, including the general population, children, elderly, and beneficiaries with disabilities or mental retardation. All beneficiaries will receive a standard benefit package; however, optional benefits may be targeted toward the needs of specific recipients. .
- **Cost Sharing.** The waiver requires most members to pay a portion of their covered services through co-payments and premiums on an income-based sliding fee scale. (Cost-sharing requirements do not apply to certain member categories, such as pregnant women, children, and members who have already reached their annual cap.)
- **Enable Beneficiaries to Enroll in Employer-Sponsored Health Insurance.**
- **Integrating Care.** The Medicaid program is to coordinate mental health, physical health, mental retardation, and developmental disabilities services.
- **Disease Management.**
- **Get Healthy Accounts.** KyHealth Choices will provide incentives to beneficiaries who are engaging in healthy behaviors.

In addition, the waiver will offer a consumer-directed option to certain individuals who are enrolled in a long-term care benefits package. To be eligible, individuals must be able to direct their own care and understand the risks and responsibilities associated with managing their own care. Members who choose this option may access non-medical and non-residential services (e.g., home adaptations to enable them to stay at home) that best meet their needs.

The **Vermont** initiative is the first of its kind in the nation and will test the impact of a Federal funding cap on Medicaid spending coupled with State flexibility to manage Medicaid health services. The program calls for the Vermont Agency of Human Services to contract with the Office of Vermont Health Access (OVHA), the State's existing Medicaid demonstration project, to serve as a publicly sponsored managed care organization (MCO). OVHA will receive monthly capitation payments to cover the health needs of all Medicaid beneficiaries. CMS approved authorizing up to a maximum of $4.7 billion to the State for Federal fiscal years 2006-2010. If costs exceed the $4.7 billion ceiling, however, the State will be forced to absorb all the additional expense with State funds.

The "Vermont Health Access Program" (VHAP) covers mandatory, optional, and expansion populations. Under VHAP, Vermont covers children up to 300 percent of the Federal poverty level (FPL), parents of those children up to 185 percent of FPL, and childless adults up to 150 percent. Although no changes in eligibility or benefits will be made for the mandatory Medicaid populations, the State will be able to change the benefit package (with legislative approval) for optional and expansion populations, so long as the total change in spending does not exceed 5 percent.

The Office of Vermont Health Access will enter into interagency agreements with the various State agencies (such as the Department of Disabilities, Aging and Independent Living) that currently administer Medicaid programs being subsumed into the new demonstration program, including the State's pharmacy program for low-income persons. Expenditures from these agencies will be reported in the aggregate under the demonstration.

Vermont also received Federal approval in June 2005 for a long-term care plan, Choices for Care, that provides an entitlement to either nursing home care or home- and community-based services (HCBS) for Medicaid-eligible persons, consistent with their needs and choices. (More information on this program is included in this report under Rebalancing Long-Term Care Services.) This program will operate, in effect, through a "global" budget because Medicaid funds will not be allocated in separate "silos" for nursing homes or HCBS, but can be spent on whichever service is most appropriate for persons found to be eligible for long-term care.

West Virginia's new Medicaid coverage consists of two tiers of services. The basic level includes fewer benefits than the State's Medicaid program currently provides. The basic level limits children to four prescription drugs per month, and places new limits on dental, hearing and vision services. In addition, the basic plan eliminates coverage for skilled nursing care, orthotics, prosthetics, tobacco cessation programs, nutrition education, diabetes care, and essential mental health and substance abuse services for children. The enhanced level provides coverage for services limited or eliminated in the basic level plan. However, children are only eligible for enhanced level coverage if their parents sign a "Medicaid Member Agreement." This agreement requires beneficiaries to promise not to miss medical appointments, to always follow doctors' advice and only to use the emergency room for emergencies. The plan returns children whose parents do not follow their member agreements to the basic level of services. Families may re-apply for enhanced coverage after 12 months or when renewing Medicaid coverage.

West Virginia's new plan requires pediatricians and other children's health care providers to report parents who not meet the terms of their agreements. Although Federal Medicaid law requires that all States provide Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to children in their Medicaid programs, West Virginia's plan changed its definition of the services to exclude follow-up diagnostic and treatment services.

(**Editor's note:** Information regarding the Medicaid waivers and Idaho State Plan Amendments is largely taken from the National Conference of State Legislatures' (http://www.ncsl.org) and CMS' (http://www.cms.hhs.gov) Web sites.)

Medicaid Reorganization

In 2005 **Kansas** Governor Kathleen Sebelius signed S.B. 272 which created a new State agency called the Kansas Health Policy Authority (KHPA). On July 1, 2006, the KHPA, housed within the executive branch, assumed operational and purchasing responsibilities for Kansas health programs, including the regular medical portion of Medicaid, Health Wave (SCHIP), the State health care benefits program, workers' compensation, the Medicaid Management Information System, MediKan, pharmacy programs, and the Kansas Business Health Partnership.

The agency is to improve the health of all Kansans, and to develop a coordinated health policy agenda. The KHPA is designed to reduce health care costs by streamlining all health programs under one division and consolidating purchasing power of the State.

Olmstead Initiatives:

In 1999 the U.S. Supreme Court ruled in the *Olmstead v. L.C. and E.W.* decision that States are to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA), which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. As a result, most States developed plans for increasing opportunities for community-based services in lieu of institutional or nursing facility care for those who so choose. States have passed laws, implemented policies, developed Medicaid waivers, and applied for Federal grants to rebalance long-term care services to reflect an array of options for individuals with disabilities or who are elderly. Such initiatives include consumer or self-directed services, money follows the person, and flexible funding among funding streams to support individuals in their communities using services of choice.

Consumer Choice

On June 3, 2005, **Colorado** Governor Bill Owens signed H.B. 1243 which relates to consumer-directed care under the Colorado Medical Assistance Act. The bill extends the option of receiving HCBS through the consumer-directed care service model to all Medicaid recipients who are enrolled in an HCBS waiver for which the Department of Health Care Policy and Financing has Federal waiver authority, including HCBS for persons with traumatic brain injury. (See the legislation in the Appendix on p. 72.)

Oklahoma Governor Brad Henry signed legislation on June 6, 2005 establishing the Self-Directed Care Act. S.B. 1015 offers persons with disabilities receiving HCBS the option to choose providers of services and to direct the delivery of services. The legislation also creates the Strategic Planning Committee on the Olmstead Decision. (See the legislation in the Appendix on p. 80.)

In accordance with the legislation the Health Care Authority and the Department of Human Services are to develop a pilot program and conduct a feasibility study on the future design and implementation of expanding the home- and community-based waiver program to include additional people with developmental disabilities, spinal cord injury, or traumatic brain injury. Before allocating any new monies to such a program, however, the Department and the Authority shall prepare and submit to the Legislature the results of the feasibility study and a fiscal impact statement.

Money Follows the Person

On March 8, 2006, **New Mexico** Governor Bill Richardson signed H.B. 353, the Money Follows the Person (MFP) Act, which provides a mechanism for people with disabilities to be able to move to community living from an institution-like setting. The new law allows a person in a nursing facility to choose community living, and have the money that has supported the person in the facility to follow the person to the community.

The legislation fits with the Federal legislation (DRA of 2005) signed into law by President Bush February 15, 2006. The Federal legislation allows States to choose MFP and be eligible for enhanced Medicaid match to encourage adoption of MFP. New Mexico would get an 86/14

match for Federal Medicaid funds to assist in the transition period as the State implements MFP. (See the legislation in the Appendix on p. 91.)

Rebalancing Long-Term Care Services

Vermont Governor Jim Douglas signed S.B. 543 on June 6, 2005 authorizing the Department of Aging and Independent Living to implement the Long-term care Medicaid 1115 Waiver applied for by the agency. The bill establishes policy for reassessment of entitlement to services by individuals currently receiving long-term care through the department, creates appropriate waiting lists for services under the waiver, and prioritizes homemaker services to individuals who have high needs as defined under the waiver.

H.B. 543 also established a task force on the future sustainability of nursing homes and directs the task force to report recommendations on policy changes needed in this area to certain legislative committees by January 15, 2007. The bill also modifies the Medicaid eligibility requirements for working individuals with disabilities to exclude unearned income and to increase the asset limit.

On June 13 the U.S. Department of Health and Human Services approved Vermont's Long-Term Care Plan, a section 1115 demonstration waiver, which is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options. The demonstration would not include children or individuals receiving institutional services through ICFs/MR (Intermediate Care Facilities for Persons with Mental Retardation). The waiver is to expand its long-term-care coverage to home health and other services besides nursing-home care. The pilot will involve 4,500 Medicaid beneficiaries who are 65 or older or have physical disabilities.

On June 22, 2006, **New Jersey** Governor John Corzine signed A.B. 2823 which enacts the “Independence, Dignity and Choice in Long-Term Care Act” to reallocate Medicaid long-term care expenditures to create maximum flexibility between funding for institutional care and funding for care provided in the community. Medicaid home- and community-based long-term care options that are available in the State, include, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

The bill is to ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home- and community-based settings when it does not compromise Federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in the State. (See the legislation in the Appendix on p. 92.)

In July 2006 the Long Term Care Services and Reform Act (Senate 2628 Substitute A, as amended) passed by the **Rhode Island** General Assembly became effective. The law directs the Department of Human Services (DHS) to implement a model system for integrated long-term care that expands the capacity of the long-term care system as a whole to support consumer choice and independence. The new law requires a unified long-term care budget with savings achieved by reducing nursing home days paid by Medicaid to be used to promote and

strengthen community-based alternatives. The law is designed to enable consumers to access coordinated services, as well as to assure quality outcomes through certification standards, performance measures, and incentives and rewards that promote service excellence.
Key provisions of the bill include:

- **Least restrictive setting requirement** – Beginning July 1, 2006, the DHS is authorized to allocate existing Medicaid resources as needed to ensure that those in need of long-term care and support services receive them in the least restrictive setting appropriate to their needs and preferences. The department is authorized to use screening criteria to avoid unnecessary institutionalization of persons during the full eligibility determination process for Medicaid community-based care.

- **Unified long-term care budget** – Beginning July 1, 2007, a unified long-term care budget is to be combined in a single line-item within the DHS budget, including the annual DHS Medicaid appropriations for nursing facility and community-based long-term care services (including adult day care, home health, and personal care in assisted living settings). Also beginning July 1, 2007, the total system savings attributable to the value of the reduction in nursing home days paid for by Medicaid shall be allocated for the express purpose of promoting and strengthening community-based alternatives.

- **Administration and regulations** – DHS is authorized to develop and submit any requests for waivers, demonstration projects, grants, and state plan amendments or regulations that may be considered necessary and appropriate to support the general purposes of this statute.

- **Reporting** – Annual reports shall be submitted by the department to the Joint Legislative Committee on Health Care Oversight as well as the finance committees of both the Rhode Island Senate and the House of Representatives and shall include estimates of the investments necessary to provide stability to the existing system and establish the infrastructure and programs required to achieve system-wide reform.

- **Rate reform** – By January 2008, DHS is to design and require all service providers to provide cost reports for all community-based long-term services.

- **System screening** – By January 2008, DHS is to develop and implement a screening strategy for the purpose of identifying entrants to the publicly financed long-term care system prior to application for eligibility, as well as defining their potential service needs.

To help with the administrative aspect of the new law, DHS submitted an application to CMS for a Real Choice Systems Change grant. CMS awarded $2,177,665 for a five-year implementation of long-term care system reform beginning in October 2006. The initial period through June 2007 is designated as a strategic planning phase of the CMS grant award.

Nursing Facility Transition services have been incorporated into the DHS-funded HCBS waiver programs. These efforts have been as the result of a nursing facility grant that successfully transitioned 625 persons through September 2006. This service allows payment for one time expenses such as housing security deposits or furnishings to individuals transferring to a home- and community-based waiver from the community. (See legislation in the Appendix on p. 98.)

U.S. Department of Health and Human Services Grants

President Bush issued an Executive Order on June 18, 2001 establishing the New Freedom Initiative (NFI) as a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. Congress has appropriated funding to the Centers for Medicare and Medicaid Services (CMS) for grants to assist States in implementing systemic changes to better serve individuals with disabilities in the setting of their choosing.

The Deficit Reduction Act of 2005 created the Money Follows the Person (MFP) Rebalancing Demonstration to assist States to make changes to their long-term care support systems. Proposals were due November 1, 2006 and CMS awarded grants to 31 States. CMS awarded $1,435,709,479 in MFP grants with States proposing to transition 37,731 individuals out of institutional settings over the five-year demonstration period.

Real Choices Systems Change Grants

In 2006 the U.S. Department of Health and Human Services (HHS) awarded eight States funding under the "Real Choice Systems Change Grants for Community Living". Under this program, nearly $20 million was awarded to States for programs for people with disabilities or long-term illnesses. The grant program helps States and territories "rebalance" their long-term support programs to help people with chronic illness or disabilities reside in their homes and participate fully in community life. Receiving the 2006 awards were **California**, **Kansas**, **Michigan**, **New Jersey**, **New York**, **North Carolina**, **Rhode Island**, and **Virginia**.

CMS required States receiving grant money to address at least three of the six goals necessary to transform Medicaid program incentives away from institutional care with options for care at home and in the community. The goals include:

- Improving access to information regarding the full range of community-based services available;
- Promulgation of more self-directed service delivery systems;
- Implementation of comprehensive quality management system;
- Development of information technology to support community living;
- Flexible financing arrangements that promote community living options; and
- Long-term supports coordinated with affordable and accessible housing.

Aging and Disability Resource Center Grants

In 2006 HHS Secretary Mike Leavitt announced nearly $6 million in additional funding to 22 States to expand their efforts to establish single entry points to long-term care for families who are trying to learn about and access services in their communities. These Aging and Disability Resource Center (ADRC) grants are part of the President's New Freedom Initiative to help consumers make informed decisions about their care options.

As of 2006 43 States have received over $40 million in support under the ADRC initiative, which is jointly administered by the Administration on Aging (AoA) and CMS. States are using ADRC funds to better coordinate and redesign their existing methods for providing seniors, younger people with disabilities, and family caregivers with information and personalized assistance in accessing services such as meals-on-wheels, personal care, housekeeping, specialized transportation, assisted living, and nursing home care.

Ticket to Work and Work Incentives Act (TWWIIA)
In Fiscal Year 2006 CMS awarded $25 million in grants to 43 States and the District of Columbia to help people with disabilities find and keep work without losing their health benefits. With these awards, HHS has given a total of $125 million in Medicaid Infrastructure Grants (MIG) to 47 States and the District of Columbia under this program. Thirty-one States have implemented Medicaid Buy-In programs that ensure health coverage for over 76,000 people enrolled in the program who work.

Since Fiscal Year 2001, CMS has committed a total of over $152 million in grants to States to implement Demonstrations to Maintain Independence and Employment (DMIE). This demonstration is designed to assist States in testing the hypothesis that providing health care and other services early in the progression of a disease may help a person remain self-sufficient and prevent the onset of cash assistance. The **District of Columbia**, **Hawaii**, **Kansas**, **Louisiana**, **Minnesota**, **Mississippi**, **Rhode Island**, and **Texas** have been awarded grants.

***Independence Plus* Initiative**
The *Independence Plus* Initiative began in 2002 and expedites the ability of States to request waivers or demonstrations that offer individuals or their families greater opportunities to take charge of their own health and direct their own services. There are eleven (11) approved *Independence Plus* programs in ten (10) States (**California**, **Connecticut**, **Delaware**, **Florida**, **Louisiana**, **Maryland**, **New Hampshire**, **New Jersey**, **North Carolina** (2), and **South Carolina**). Connecticut was a new waiver in 2005. Maryland and California were approved in 2004, but were effective in 2005.

Collectively, these States permit 34,456 individuals with long term care needs to self-direct their services. Additionally, CMS has awarded $5.4 million in Real Choice Systems Change grants to twelve (12) States (**Colorado**, **Connecticut**, **Florida**, **Georgia**, **Idaho**, **Louisiana**, **Maine**, **Massachusetts**, **Michigan**, **Missouri**, **Montana**, and **Ohio**) to develop Independence Plus programs.

Prevention:

Shaken Baby Syndrome

Several States have taken a proactive stance in recent years regarding the prevention of shaken baby syndrome. Below are some examples of States that have passed such programs.

On July 14, 2005, **Illinois** Governor Rod Blagojevich signed S.B. 506 creating the Shaken Baby Prevention Act. The bill requires the Director of Public Health to establish a statewide Shaken Baby Prevention Program to educate parents about the dangers of shaken baby syndrome and provide alternative techniques to venting anger and frustration. The bill also provides that the department may establish a support service for parents who struggle with infant crying. The support service may include telephone consultation and referrals to appropriate professional assistance. (See p. 102 of the Appendix for the legislation.)

Wisconsin Governor Jim Doyle signed S.B. 221 to help prevent children from becoming victims of shaken baby syndrome on Tuesday, March 21, 2006. The bill calls for education of parents and caregivers, training for day care providers, and instruction regarding shaken baby syndrome and impacted babies for middle school and high school students. S.B. 221 expands the State's educational efforts on shaken baby syndrome—requiring the production and distribution of educational materials for parents and caregivers on the dangers of shaking a child.

New York Governor George Pataki signed S.B. 7008 on June 28, 2006. This law requires the Department of Health to develop and implement a shaken baby syndrome public educational campaign to inform the general public about brain injuries and other harmful effects that may result from shaking infants and children under five years of age. Referred to as "Cynthia's Law," the new law creates the crime of reckless assault of a child for persons aged 18 or older when such a person recklessly causes serious physical injury to the brain of a child less than five years old by shaking the child or by slamming or throwing the child so as to impact the child's head on a hard surface or object. The legislation also requires the Department of Health to develop a Shaken Baby Syndrome Public Educational Campaign to inform the general public about brain injuries and other harmful effects that may result from shaking infants and children under the age of five. Upstate New York developed a shaken baby syndrome program beginning in December 1999. (See p. 104 of the Appendix for the legislation.)

On July 10, 2006, **Rhode Island** Governor Donald L. Carcieri signed H.B. 6903 which established the Shaken Baby Syndrome Prevention Initiative calling for the Department of Health in collaboration with the Department of Children, Youth, and Families, and other State agencies serving families and children, the medical community, law enforcement, human service providers, and child advocacy organizations to develop and implement a comprehensive, statewide initiative to reduce death and disability resulting from shaken baby syndrome.

On November 16, 2006, **Massachusetts** Governor Mitt Romney signed a comprehensive measure to prevent shaken baby syndrome (SBS) in the Commonwealth of Massachusetts. The measure directs the Massachusetts Department of Public Health to collaborate with the Department of Social Services and the Massachusetts Children's Trust Fund and other private and public agencies to develop and implement a statewide SBS prevention initiative. The initiative will include a hospital-based program for parents of newborns; education and training programs for parents, caregivers, and professionals; support for victims of shaken baby syndrome and their families; and the creation of a surveillance and data collection program to measure the incidence of SBS and traumatic brain injury in infants and children in the Commonwealth of Massachusetts.

Traffic Safety

In keeping with Federal law, the National Highway Traffic Safety Administration (NHTSA) provides funding to encourage States to pass laws and implement programs designed to reduce traffic-related injuries and fatalities. Funding is available to States to increase safety belt use rates and to implement effective programs to reduce traffic safety problems resulting from impaired driving. With regard to seat belts a State is eligible for an incentive grant if the State requires all passengers in all seating positions to be belted; has a primary enforcement safety belt law; minimum fines or points for violations of seat belt and child restraint laws; statewide special enforcement program for occupant protection, a statewide child passenger protection education program, and child passenger protection law. NHTSA also administers other incentive grants.

Bicycle Helmets

The first bicycle helmet law was passed in California in 1986 and became effective in 1987. As of January 2006, 20 States, the District of Columbia, and at least 148 municipal localities have enacted age-specific bicycle helmet laws. Most of these laws cover bicyclists under 16.

On June 15, 2005, **New Hampshire** Governor John Lynch signed H.B. 118 mandating the use of bicycle helmets for children 16 years of age or younger, adding New Hampshire to the list of States that have laws governing bicycle helmet usage.

DWI

On August 21, 2006, **North Carolina** Governor Mike Easley signed new legislation that will make it extremely difficult for drunk drivers to escape conviction. The DWI (Driving While Intoxicated) law was effective December 2006, and stipulated that a driver with a blood-alcohol level of 0.08 grams per deciliter (g/dl) can be convicted of DWI (driving while impaired). The new legislation emerged after a special task force on drunken driving enforcement across the State found that more than one-third of DWI defendants who went to trial were acquitted despite tests showing blood-alcohol levels higher than the legal limit of 0.08 g/dl.

Child Safety Restraints/Booster Seats

The appropriate restraint system for children 4 to 7 is either a front-facing safety seat or a booster seat, depending on the child's height and weight. At the end of 2006, 23 States had adopted a booster seat law that partially covers children up to age 8, and 12 other States have yet to adopt any booster seat law. In 2006 Hawaii, Kansas, Missouri, and Wisconsin adopted the optimal law while Alabama enacted a law covering children only up to age five. Fifteen States and the District of Columbia have an optimal booster seat law. Thirty-five States still need an optimal booster seat law to cover all children ages 4 to 8. (Advocates for Highway and Auto Safety).

On February 2, 2006, **Wisconsin** Governor Jim Doyle signed AB 618, the "Child Passenger Safety Bill," requiring children ages up to age 8 that are less than 80 pounds and less than 4 feet 9 inches tall to ride in booster or safety seats. Children who exceed those height and weight levels would need only to be strapped in by a seatbelt, as required under previous law. The bill includes a six-month grace period after it is enacted during which warnings will be given instead of citations.

Kansas Governor Kathleen Sebelius signed H.B. 2611, the booster seat law for children, March 27, 2006. The law went into effect July 1, 2006. The law requires children ages 4 through 8 who either weigh less than 80 pounds. or are shorter than 4 feet 9 inches in height to be placed in an "appropriate child passenger restraining system" that meets Federal guidelines.

Alabama Governor Bob Riley signed S.B. 38 April 17, 2006. This law requires children to be in rear-facing infant car seats until they are 1 year or weigh 20 pounds. After that, they must be in forward-facing child car seats until they are 5 or weigh 40 pounds, in booster seats until they turn 6, and in regular seat belts until they turn 15. The new law was effective July 1, 2006. Prior to enactment, children 5 and older could legally use regular adult seat belts.

S.B. 38 requires every person transporting a child in a motor vehicle operated on the roadways, streets, or highways to conform to the following: (1) infant only seats used in the rear-facing position for infants until at least 1 year of age or 20 pounds; (2) convertible seats in the forward position or forward-facing seats until the child is at least 5 years of age or 40 pounds; (3) booster seats until the child is 6 years of age; and (4) seat belts until 15 years of age.

On June 6, 2006, **Hawaii** Lt. Governor James R. "Duke" Aiona, as Acting Governor, signed S.B. 427, requiring child safety seat or booster seat usage for children 4 through 7 years of age.

Missouri Governor Matt Blunt signed S.B. 872, relating to the safe operation of motor vehicles to ensure the safety of highway workers, emergency workers, and other motorists, including young children, on June 28, 2006. The Child Passenger Protection bill requires children of certain ages, weights, and heights to be restrained by a child passenger restraint system, booster seat or safety belt. Under the new law, children younger than 4 years old are required to use a child passenger restraint system. Children weighing less than 40 pounds, regardless of age, are also required to use a child passenger restraint system appropriate for the child.

The bill requires children who are between 4 and 7 years old, who weigh between 40 and 80 pounds, and who are less than 4 feet 9 inches tall to be secured in a child passenger restraint system or booster seat. Children weighing at least 80 pounds or who are taller than 4 feet 9 inches must be secured by a safety belt or booster seat appropriate for the child.

Primary Enforcement of Seat Belt Usage

During the 2005-2006 legislative sessions, a number of states introduced bills relating to primary enforcement. However, only one State (South Carolina) was successful in passing a primary seat belt law in 2005, and only three (Alaska, Kentucky and Mississippi) in 2006. Primary seat belt laws allow law enforcement officers to ticket a driver for not wearing a seat belt. (Secondary seat belt laws allow law enforcement officers to only issue a ticket for not wearing a seat belt when there is another citable traffic infraction.) Congress established an incentive grants program in 2005 to encourage States to enact and enforce laws requiring the use of seat belts in passenger motor vehicles.

As of 2007, about half the States have primary seat belt laws, although seat belt laws vary greatly from State to State, depending on the age of the rider and in what seat he or she is sitting. Of the 26 States with primary seat belt laws, only eight (Connecticut, Hawaii, Iowa, New Mexico, New York, North Carolina, Oregon and Texas) originally had primary enforcement laws. All other States with primary enforcement laws did so by converting their pre-existing secondary enforcement laws to primary enforcement. New Hampshire is the only State that has not enacted either a primary or a secondary seat belt law. (The State does have a mandatory child passenger safety law that covers children under 18.)

In 2005 **South Carolina** legislators passed S.B. 1 which would delete exemption for back seat passengers from seat belt law and would allow primary enforcement of the seat belt law. The bill became law without Governor Mark Sanford's signature and became effective on December 9, 2005.

On January 31, 2006, **Alaska** Governor Frank Murkowski signed S.B. 87, the primary seat belt bill, which also requires persons 16 and older to wear a seat belt while in a motor vehicle being driven on the highway. The new law became effective May 1, 2006. The fine for failure to wear a seat belt is $60.

Mississippi Governor Haley Barbour signed H.B. 409, primary seat-belt legislation for front seat passengers and children under 8 only, February 7, 2006. The driver of the car could then be fined as much as $25. The law went into effect on May 27, 2006.

On April 24, 2006, **Kentucky** Governor Ernie Fletcher signed primary safety belt legislation, H.B. 117, which includes a provision requiring children under the age of 16 to wear helmets when riding an all-terrain vehicle. The bill also expands testing for lead and other health problems affecting children.

Public Awareness:

March Brain Injury Awareness Month

A number of State legislatures introduce resolutions recognizing March as Brain Injury Awareness Month. On June 29, 2006, **New Jersey** Governor John Corzine signed A.J.R. 85, a joint resolution designating the month of March in each year as "Brain Injury Awareness Month." (See p. 107 of the Appendix for the resolution, as an example).

Recognizing Volunteers

In May **Oklahoma** representatives adopted H.R. 1126 recognizing volunteers who work with individuals with traumatic brain injuries.

Registry Changes:

In 2006 **Nebraska** Governor Dave Heineman signed L.B. 1178 expanding brain injury registry requirements to include rehabilitation centers. L.B .1178 deletes the reporting requirements of race and ethnicity. This report will still require cause of injury, but it must be practicable, whether the injury resulted from an incident involving the use of alcohol. This bill became effective July 14, 2006. Nebraska requires physicians and psychologists to report cases of TBI and Spinal Cord Injury (SCI) to the State health department within 30 days after case identification. Each hospital in the State is also required to report, within 30 days after a patient is discharged, any traumatic brain injury or SCI that results in inpatient admission or outpatient treatment.

Georgia Governor Sonny Perdue signed S.B. 208 in 2006. S.B. 208 makes minor revisions to the brain and spinal cord injury registry. The bill specifies that "hospitals" are required by law to report people with traumatic brain and spinal cord injuries and addresses confidentiality (i.e., HIPAA) issues. The bill also revises the definitions of traumatic brain injury and spinal cord injury and increases the reporting timeframe from 48 hours to 45 days following the injury.

The registry was initially passed in 1981 and required hospitals to report spinal cord injuries to the Division of Rehabilitation Services (DRS) for the division to send follow-up information on available services and resources. In 1985 the registry was expanded to include individuals hospitalized with TBI. From its creation in 1981 until 2004, the Central Registry was operated by the DRS through its Roosevelt Warm Springs Institute for Rehabilitation. Since 2004, the Georgia Brain & Spinal Injury Trust Fund Commission has overseen the registry. The Georgia Hospital Association forwards the data collected from the hospitals to the Commission for purposes of follow-up and determining incidence and prevalence.

State Government Reorganization and Review:

States continue to reorganize human, disability, and health services. **Indiana** Governor Mitch Daniels signed S.B. 41 on March 24, 2006. S.B. 41 established the Division of Aging as a division separate from the Division of Disability and Rehabilitative Services. The division funds long-term care through Medicaid programs and supports the development and utilization of alternatives to nursing home care. The division coordinates and funds services through a network of Area Agencies on Aging.

Colorado Governor Bill Owens signed S.B. 219 on June 6, 2006. This legislation reorganized programs administered by the State Department of Health Care Policy and Financing including the medical assistance act, the indigent care program, the children's basic health plan, the old age pension health and medical care program, and the comprehensive primary and preventive care grant program. The TBI HCB Medicaid Waiver is administered by this agency.

On April 13, 2005, **Arkansas** Governor Mike Huckabee signed H.B. 2877 establishing an orderly schedule for the abolishment of all existing State agencies, commissions, and councils during a 12-year period. However, the bill makes provision for review by the Government Efficiency and Accountability Review Subcommittee of the House and Senate Interim Committees on State Agencies and Governmental Affairs. It declared that all State agencies and entities listed in the bill were to be abolished on June 30, 2007, unless the General Assembly recommends continuing the agency or transferring to another State agency. Some of the entities listed include the Department of Human Services, Division of Aging and Adult Services, Division of Medical Services; Department of Health, Division of Emergency Medical Services, Emergency Medical Services Advisory Council, and the Arkansas Head Injury Foundation.

Appendix

TBI ADVISORY BOARD

THE STATE OF MARYLAND

MARYLAND 2005 REGULAR SESSION - 419TH SESSION OF THE GENERAL ASSEMBLY

SENATE BILL 395

BY: SENATORS KELLEY, BRITT, BROCHIN, COLBURN, CURRIE, DEGRANGE, DELLA, GARAGIOLA, GREEN, KASEMEYER, LAWLAH, MUNSON, STONE, AND TEITELBAUM
INTRODUCED AND READ FIRST TIME: FEBRUARY 3, 2005
ASSIGNED TO: EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE
REPORT:
FAVORABLE WITH AMENDMENTS SENATE ACTION: ADOPTED READ SECOND TIME: MARCH 15,

VERSION: Enrolled

VERSION-DATE: April 6, 2005

SYNOPSIS: AN ACT concerning

State Traumatic Brain Injury Advisory Board

FOR the purpose of establishing a State Traumatic Brain Injury Advisory Board; specifying the membership and duties of the Advisory Board; providing for staffing of the Advisory Board; requiring the Advisory Board to meet at least once within a certain time period; requiring the Advisory Board to elect a chair once every year; providing for certain term limits for members of the Advisory Board; prohibiting members of the Advisory Board from receiving compensation for serving on the Advisory Board; authorizing reimbursement to members of the Advisory Board for certain expenses; requiring the Advisory Board to submit certain reports to the Governor and to the General Assembly on or before a certain date each year; requiring the Advisory Board to disseminate copies of the annual report to the President of the Senate, Speaker of the House, and the Secretary of each Department represented on the Advisory Board each year; defining a certain term; [A> PROVIDING FOR THE TERMINATION OF THIS ACT; <A] and generally relating to the State Traumatic Brain Injury Advisory Board.

BY adding to Article - Health - General Section 13-2101 through 13-2105 to be under the new subtitle "Subtitle 21. State Traumatic Brain Injury Advisory Board" Annotated Code of Maryland (2000 Replacement Volume and 2004 Supplement)

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]

TEXT: SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

[A> SUBTITLE 21. STATE TRAUMATIC BRAIN INJURY ADVISORY BOARD. <A]

[A> 13-2101. <A]

[A> IN THIS SUBTITLE, "ADVISORY BOARD" MEANS THE STATE TRAUMATIC BRAIN INJURY ADVISORY BOARD. <A]

[A> 13-2102. <A]

[A> THERE IS A STATE TRAUMATIC BRAIN INJURY ADVISORY BOARD. <A]

[A> 13-2103. <A]

[A> THE ADVISORY BOARD CONSISTS OF THE FOLLOWING 36 VOTING MEMBERS: <A]

[A> (1) THE FOLLOWING TWO MEMBERS, WHO SHALL SERVE EX OFFICIO: <A]

[A> (I) ONE MEMBER OF THE SENATE, TO BE APPOINTED BY THE PRESIDENT OF THE SENATE; AND <A]

[A> (II) ONE MEMBER OF THE HOUSE OF DELEGATES, TO BE APPOINTED BY THE SPEAKER OF THE HOUSE; <A]

[A> (2) THE SECRETARY OF DISABILITIES, OR THE SECRETARY'S DESIGNEE; <A]

[A> (3) THE SECRETARY OF HEALTH AND MENTAL HYGIENE, OR THE SECRETARY'S DESIGNEE; <A]

[A> (4) THE SECRETARY OF THE STATE DEPARTMENT OF EDUCATION, OR THE SECRETARY'S DESIGNEE; <A]

[A> (5) ONE REPRESENTATIVE OF THE STATE DEPARTMENT OF EDUCATION, DIVISION OF REHABILITATION SERVICES, APPOINTED BY THE DIRECTOR OF THE DIVISION; <A]

[A> (6) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DEVELOPMENTAL DISABILITIES ADMINISTRATION, APPOINTED BY THE DIRECTOR OF THE ADMINISTRATION; <A]

[A> (7) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, MENTAL HYGIENE ADMINISTRATION, APPOINTED BY THE DIRECTOR OF THE ADMINISTRATION; <A]

[A> (8) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, FAMILY HEALTH ADMINISTRATION, CENTER FOR PREVENTIVE HEALTH SERVICES, APPOINTED BY THE DIRECTOR OF THE CENTER; <A]

[A> (9) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, FAMILY HEALTH ADMINISTRATION, OFFICE FOR GENETICS AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS, APPOINTED BY THE DIRECTOR OF THE OFFICE; <A]

[A> (10) ONE REPRESENTATIVE OF THE MARYLAND INSTITUTE OF EMERGENCY MEDICAL SERVICES SYSTEMS, APPOINTED BY THE DIRECTOR OF THE INSTITUTE; <A]

[A> (11) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OFFICE OF HEALTH SERVICES, APPOINTED BY THE DIRECTOR OF THE OFFICE; <A]

[A> (12) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, ALCOHOL AND DRUG ABUSE ADMINISTRATION, APPOINTED BY THE DIRECTOR OF THE ADMINISTRATION; <A]

[A> (13) FOUR REPRESENTATIVES OF THE BRAIN INJURY ASSOCIATION OF MARYLAND, APPOINTED BY THE EXECUTIVE DIRECTOR OF THE ASSOCIATION; <A]

[A> (14) ONE REPRESENTATIVE OF THE MARYLAND STATEWIDE INDEPENDENT LIVING COUNCIL, APPOINTED BY THE EXECUTIVE DIRECTOR OF THE COUNCIL; <A]

[A> (15) ONE REPRESENTATIVE OF THE MARYLAND DISABILITY LAW CENTER, MARYLAND'S PROTECTION ADVOCACY SYSTEM, APPOINTED BY THE DIRECTOR OF THE OFFICE; <A]

[A> (16) ONE REPRESENTATIVE OF THE NATIONAL INSTITUTE OF HEALTH, APPOINTED BY THE DIRECTOR OF THE INSTITUTE; AND <A]

[A> (17) THE FOLLOWING 16 MEMBERS, APPOINTED BY THE GOVERNOR: <A]

[A> (I) ONE REPRESENTATIVE OF STATE OR LOCAL LAW ENFORCEMENT; <A]

[A> (II) SIX MARYLAND CITIZENS WHO HAVE EXPERIENCED A TRAUMATIC BRAIN INJURY**;** <A]

[A> (III) FIVE MARYLAND CITIZENS WHO ARE CURRENTLY CARING FOR, OR ARE FAMILY MEMBERS OF, INDIVIDUALS WHO HAVE EXPERIENCED A TRAUMATIC BRAIN INJURY; AND <A]

[A> (IV) FOUR PROFESSIONALS WITH SPECIALIZED EXPERIENCE IN PROVIDING SERVICES TO INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES OR TRAUMATIC BRAIN INJURY PREVENTION ACTIVITIES. <A]

[A> 13-2104. <A]

[A> (A) (1) THE TERM OF A MEMBER IS 3 YEARS. <A]

[A> (2) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES. <A]

[A> (3) A MEMBER APPOINTED TO FILL A VACANCY IN AN UNEXPIRED TERM SERVES ONLY FOR THE REMAINDER OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES. <A]

[A> (4) A MEMBER OF THE ADVISORY BOARD MAY NOT SERVE MORE THAN TWO CONSECUTIVE TERMS. <A]

[A> (5) THE TERMS OF THE MEMBERS OF THE ADVISORY BOARD ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS ON OCTOBER 1, 2005. <A]

[A> (B) THE MEMBERS OF THE ADVISORY BOARD SHALL ELECT A CHAIR OF THE ADVISORY BOARD EACH YEAR. <A]

[A> (C) A MAJORITY OF THE MEMBERS PRESENT AT A MEETING SHALL CONSTITUTE A QUORUM FOR TRANSACTING BUSINESS OR PERFORMING ANY DUTIES. <A]

[A> (D) THE ADVISORY BOARD SHALL MEET AT LEAST ONCE EVERY OTHER MONTH. <A]

[A> (E) A MEMBER OF THE ADVISORY BOARD: <A]

[A> (1) MAY NOT RECEIVE COMPENSATION; BUT <A]

[A> (2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET. <A]

[A> (F) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE DEPARTMENT OF DISABILITIES SHALL JOINTLY PROVIDE STAFF SUPPORT AND TECHNICAL ASSISTANCE FOR THE ADVISORY BOARD. <A]

[A> 13-2105. <A]

[A> THE ADVISORY BOARD SHALL: <A]

[A> (1) INVESTIGATE THE NEEDS OF CITIZENS WITH TRAUMATIC BRAIN INJURIES; <A]

[A> (2) IDENTIFY GAPS IN SERVICES TO CITIZENS WITH TRAUMATIC BRAIN INJURIES; <A]

[A> (3) FACILITATE COLLABORATION AMONG STATE AGENCIES THAT PROVIDE SERVICES TO INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES; <A]

[A> (4) FACILITATE COLLABORATION AMONG ORGANIZATIONS AND ENTITIES THAT PROVIDE SERVICES TO INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES; <A]

[A> (5) ENCOURAGE AND FACILITATE COMMUNITY PARTICIPATION IN PROGRAM IMPLEMENTATION; <A]

[A> (6) ISSUE AN ANNUAL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH SECTION 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON OR BEFORE NOVEMBER 30, 2005, AND EACH NOVEMBER 30 THEREAFTER SUMMARIZING THE ACTIONS OF THE ADVISORY BOARD AND CONTAINING RECOMMENDATIONS FOR: <A]

[A> (I) PROVIDING OVERSIGHT IN ACQUIRING AND UTILIZING STATE AND FEDERAL FUNDING DEDICATED TO SERVICES FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES; <A]

[A> (II) BUILDING PROVIDER-CAPACITY AND PROVIDER-TRAINING THAT ADDRESS THE NEEDS OF INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES; AND <A]

[A> (III) IMPROVING THE COORDINATION OF SERVICES FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURIES; AND <A]

[A> (7) DISSEMINATE COPIES OF THE ANNUAL REPORT TO THE PRESIDENT OF THE SENATE, SPEAKER OF THE HOUSE, AND THE SECRETARY OF EACH DEPARTMENT REPRESENTED ON THE ADVISORY BOARD. <A]

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2005. [A> IT SHALL REMAIN EFFECTIVE FOR A PERIOD OF 3 YEARS AND, ON SEPTEMBER 30, 2008, WITH NO FURTHER ACTION REQUIRED BY THE GENERAL ASSEMBLY, THIS ACT SHALL BE ABROGATED AND OF NO FURTHER FORCE AND EFFECT. <A]

SPONSOR: Nathan-Pulliam

THE STATE OF NEVADA

NEVADA 73RD REGULAR SESSION

SENATE BILL 187

SENATE BILL NO. 187 - COMMITTEE ON HUMAN RESOURCES AND EDUCATION
(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON PERSONS WITH DISABILITIES)

MARCH 15, 2005
REFERRED TO COMMITTEE ON HUMAN RESOURCES AND EDUCATION
SUMMARY - REVISES PROVISIONS RELATING TO PAYMENT OF PER DIEM AND TRAVEL EXPENSES FOR MEMBERS OF ADVISORY COMMITTEE ON TRAUMATIC BRAIN INJURIES. (BDR 38-686)
FISCAL NOTE: EFFECT ON LOCAL GOVERNMENT: NO.
EFFECT ON THE STATE: YES.

VERSION: Introduced

VERSION-DATE: March 15, 2005

SYNOPSIS: AN ACT relating to persons with disabilities; authorizing the members of the Advisory Committee on Traumatic Brain Injuries to receive the per diem allowance and travel expenses provided for state employees generally in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law creates the Advisory Committee on Traumatic Brain Injuries. (NRS 426A.060) Members of the Committee serve without compensation and are not entitled to receive the per diem allowance or travel expenses provided for state officers and employees generally, unless the per diem allowance or travel expenses are paid from a source other than the State and the payment is not inconsistent with any condition attached to the acceptance of the money. (NRS 426A.060)

This bill entitles members of the Committee engaged in the business of the Committee to receive the per diem allowance and travel expenses provided for state officers and employees generally to the extent that these expenses are included in the budget of the Department of Human Resources.

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 426A.060 is hereby amended to read as follows:

426A.060 1. The Advisory Committee on Traumatic Brain Injuries, consisting of 11 members, is hereby created.

2. The Director of the Department shall appoint to the Committee:

(a) One member who is an employee of the Office.

(b) One member who is an employee of the Division of Health Care Financing and Policy of the Department and participates in the administration of the state program providing Medicaid.

(c) One member who is a licensed insurer in this State.

(d) One member who represents the interests of educators in this State.

(e) One member who is a person professionally qualified in the field of psychiatric mental health.

(f) Two members who are employees of private providers of rehabilitative health care located in this State.

(g) One member who represents persons who operate community-based programs for head injuries in this State.

(h) One member who represents hospitals in this State.

(i) Two members who represent the recipients of health care in this State.

3. After the initial appointments, each member of the Committee serves a term of 3 years.

4. The Committee shall elect one of its members to serve as Chairman.

5. Members of the Committee [D> serve <D] [A> : <A]

[A> (A) SERVE <A] without compensation [A> ; <A] and

[A> (B) IF PROVIDED FOR IN THE BUDGET OF THE DEPARTMENT, WHILE ENGAGED IN THE BUSINESS OF THE COMMITTEE, <A] are [D> not <D] entitled to receive the per diem allowance [D> or <D] [A> AND <A] travel expenses provided for state officers and employees generally [A> . <A] [D> , except that members of the Committee may receive any per diem allowance and travel expenses that may be authorized by the Committee if the payment of the per diem allowance and travel expenses: <D]

[D> (a) Is made from money received by the Committee from a source other than the State of Nevada; and <D]

[D> (b) Is not inconsistent with any condition attached to the acceptance of that money. <D]

6. The Committee may:

(a) Make recommendations to the Director of the Department and the Office relating to the establishment and operation of any program for persons with traumatic brain injuries.

(b) Make recommendations to the Director of the Department and the Office concerning proposed legislation relating to traumatic brain injuries.

(c) Collect information relating to traumatic brain injuries.

(d) Apply for grants.

(e) Accept and expend any money made available to the Committee by gift, grant, donation or bequest.

7. The Committee shall prepare a report of its activities and recommendations each year and submit a copy to the:

(a) Director of the Department;

(b) Office;

(c) Legislative Committee on Health Care; and

(d) Legislative Commission.

8. As used in this section:

(a) "Person professionally qualified in the field of psychiatric mental health" has the meaning ascribed to it in NRS 433.209.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 2. This act becomes effective on July 1, 2005.

SPONSOR: Senate Committee on Human Resources and Ed

THE STATE OF NEW HAMPSHIRE

NEW HAMPSHIRE SECOND YEAR OF THE 159TH SESSION OF THE GENERAL COURT

SENATE BILL 289

CHAPTER 184
SB 289-FN FINAL VERSION
02/09/06 0724S
05/11/06 1728EBA
2006 SESSION
06-2466
08/09

AN ACT RELATIVE TO THE BRAIN AND SPINAL CORD ADVISORY COUNCIL.
SPONSORS: SEN. BOYCE, DIST 4; REP. BOYCE, BELK 5; REP. EMERTON, HILLS 7; REP. WEYLER, ROCK 8
COMMITTEE: INTERNAL AFFAIRS

VERSION: Enacted

VERSION-DATE: May 25, 2006

SYNOPSIS:

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Six

AN ACT relative to the brain and spinal cord advisory council.

DIGEST:

AMENDED ANALYSIS

This bill changes the membership of the brain and spinal cord advisory council.

05/11/06 1728eba

TEXT: Be it Enacted by the Senate and House of Representatives in General Court convened:

184:1 Advisory Council. RSA 137-K:2 is repealed and reenacted to read as follows:

137-K:2 Advisory Council.

I. There is established the New Hampshire brain and spinal cord injury advisory council in the department.

II.(a) The advisory council shall consist of the following voting members:

(1) Two members of the Spinal Cord Injury Association, appointed by such association.

(2) Two members of the Brain Injury Association of New Hampshire, appointed by such association.

(3) Two members of the professional community, one of whom shall be in a neurological specialty, appointed by the governor.

(4) Two brain and spinal cord injury survivors, appointed by the governor.

(5) Two family members of victims of brain and spinal cord injuries, appointed by the governor.

(6) One member involved in injury prevention, appointed by the commissioner of the department of health and human services.

(7) One member of the house of representatives, appointed by the speaker of the house of representatives.

(8) One member of the senate, appointed by the senate president.

(9) One vocational rehabilitation instructor, appointed by the commissioner of the department of education.

(10) One educator, appointed by the commissioner of the department of education.

(b) The following persons or their designees shall serve as ex-officio, non-voting members of the council:

(1) The commissioner of the department of health and human services and any division administrators of the department of health and human services designated by the commissioner.

(2) The chief of the special education bureau of the department of education.

(3) The administrator of the division of vocational rehabilitation services of the department of education.

(4) The president or executive director of the Brain Injury Association of New Hampshire.

(5) The president or executive director, New Hampshire chapter of the National Spinal Cord Injury Association.

(6) The administrator of brain injury services, division of developmental services, department of health and human services.

(7) The administrator of the HCBC/ECI waiver, division of elderly and adult services, department of health and human services.

(8) The president or executive director of Granite State Independent Living.

(9) The president or executive director of the New Hampshire Developmental Disabilities Council.

(10) Representatives of other related agencies or organizations as approved by the council.

III. Members should be appointed with consideration given to statewide geographic representation.

IV. Advisory council appointments shall be for 3 years. Terms shall be staggered so that 1/3 of the positions are elected each year. Upon the completion of 2 consecutive 3-year terms, a council member shall be ineligible to serve on the council for one year. A vacancy shall be filled in the same manner as the original appointment. Such appointment shall complete the original member's term.

V. The advisory council shall have the authority to draft and adopt by-laws addressing concerns such as attendance, presentations, and notice of council meetings.

VI. The advisory council shall meet at least quarterly. At the last meeting of the state fiscal year, the regular meetings of the following state fiscal year shall be scheduled. Special meetings may be held if necessary at the call of the advisory council chair.

VII. The advisory council shall:

(a) Identify unmet needs which should be considered for support.

(b) Investigate the needs of citizens with brain and spinal cord injuries, identifying the gaps in services to these citizens, and issue an annual report to the governor, the speaker of the house, the senate president, and the commissioner of health and human services by November 1 of each year.

(c) Recommend to the commissioner priorities and criteria for disbursement of any moneys received under paragraph VIII.

(d) Hold at least 2 public hearings annually, in different regions of the state, to generate input from the public on unmet needs.

(e) Consider the feasibility of establishing a brain and spinal cord injury trust fund.

(f) Review the status of the brain injury program, established under RSA 137-K:9, and recommend to the commissioner priorities and criteria for disbursement of appropriations available to the program.

VIII. The advisory council is authorized to solicit and receive any gifts, grants, or donations made for the purposes of this chapter, and the commissioner may disburse and administer the same for the purposes of this chapter.

184:2 Effective Date. This act shall take effect upon its passage.

Effective: May 25, 2006

SPONSOR: Boyce

THE STATE OF RHODE ISLAND

RHODE ISLAND 2005-2006 LEGISLATIVE SESSION

HOUSE BILL 7546

CHAPTER 456
2006 -- H 7546 SUBSTITUTE A
ENACTED 07/07/06
INTRODUCED BY: REPRESENTATIVES MCNAMARA, AND D CAPRIO
DATE INTRODUCED: FEBRUARY 16, 2006

VERSION: Enacted - Public Law

VERSION-DATE: July 7, 2006

SYNOPSIS:

AN ACT

RELATING TO HUMAN SERVICES -- TRAUMATIC BRAIN INJURIES

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: It is enacted by the General Assembly as follows:

SECTION 1. Sections 42-12-19, 42-12-20 and 42-12-21 of the General Laws in Chapter 42-12 entitled "Department of Human Services" are hereby amended to read as follows:

42-12-19. Permanent advisory commission on traumatic brain injuries -- Commission established. -- (a) There is hereby established a permanent advisory commission on traumatic brain injuries.

(b) The purpose of the commission shall be to [D> report on all matters relating to traumatic brain injury in Rhode Island. <D] [A> : <A]

[A> (1) REPORT ON ALL MATTERS RELATING TO TRAUMATIC BRAIN INJURY IN RHODE ISLAND TO THE GOVERNOR AND THE GENERAL ASSEMBLY. <A]

[A> (2) ADVISE THE DEPARTMENT OF HUMAN SERVICES, THE DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS, AND THE DEPARTMENT OF HEALTH REGARDING THE DEVELOPMENT OF PRIORITIES AND CRITERIA FOR DISBURSEMENT OF MONEYS IN RESPONSE TO BOTH INDIVIDUAL REQUESTS AND GRANT-SEEKING ENTITIES FROM THE TRAUMATIC BRAIN INJURY FUND. SUCH PRIORITIES AND CRITERIA SHALL BE IN ACCORDANCE WITH THE EXPENDITURE GUIDELINES SET FORTH IN SECTION 42-12-28 OF THIS CHAPTER. <A]

[A> (3) ADVISE THE DEPARTMENT OF HUMAN SERVICES, THE DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS, AND THE DEPARTMENT OF HEALTH

ON ALL MATTERS REGARDING TRAUMATIC BRAIN INJURY. <A]

(c) The commission shall consist of [D> eleven (11) <D] [A> NINETEEN (19) <A] members [D> who shall serve staggered terms of one, two (2) and three (3) years <D] . They shall meet not less than [D> two (2) <D] [A> FOUR (4) <A] times a year and report their findings annually to the governor and [D> forward copies to the president of the senate and speaker of the house of representatives <D] [A> GENERAL ASSEMBLY <A] . The members of the commission shall serve without compensation. The commissioners [D> may <D] [A> SHALL <A] elect their own officers [A> ON A BIENNIAL BASIS <A] .

(d) The membership of the commission shall be as follows: the director of the department of mental health, retardation and hospitals or his or her designee; the director of the department of health or his or her designee; the director of the department of human services or his or her designee; the director of the department of education or his or her designee [A> , ALL OF WHOM SHALL SERVE EX-OFFICIO <A] ; the chief of neurosurgery at Rhode Island hospital or his or her designee; [D> two (2) members of the Rhode Island chapter of the national head injury foundation; <D] [A> THE PRESIDENT AND EXECUTIVE DIRECTOR OR TWO (2) DESIGNEES OF THE BRAIN INJURY ASSOCIATION OF RHODE ISLAND; THE DIRECTOR OF THE RHODE ISLAND DISABILITY LAW CENTER OR HIS OR HER DESIGNEE; <A] the governor or his or her designee; [D> a person appointed by the governor; the president of the senate or his or her designee; and the speaker of the house or his or her designee. <D] [A> AND TEN (10) PERSONS APPOINTED BY THE GOVERNOR AS FOLLOWS: TWO (2) PERSONS WHO ARE UNRELATED, ONE OF WHOM MUST HAVE A TRAUMATIC BRAIN INJURY, AND ONE OF WHOM MAY BE AN IMMEDIATE FAMILY MEMBER OF AN INDIVIDUAL WITH A TRAUMATIC BRAIN INJURY; ONE PERSON WHO IS A NEUROLOGIST; ONE PERSON WHO IS A PHYSIATRIST; ONE PERSON WHO IS A NEUROPSYCHOLOGIST; ONE PERSON WHO IS A COGNITIVE REHABILITATION SPECIALIST; ONE OF WHOM IS A TRAUMATIC BRAIN INJURY CASE MANAGER; ONE OF WHOM IS A PHYSICAL THERAPIST OR OCCUPATIONAL THERAPIST; ONE OF WHOM IS A REPRESENTATIVE OF A POST-ACUTE REHABILITATION FACILITY; AND ONE PERSON WHO IS A COMMUNITY-BASED SERVICE PROVIDER. <A]

(e) The first meeting of the members of the commission shall be called to order by the governor or his or her designee within ninety (90) days of [D> June 25, 1986. <D] [A> THE EFFECTIVE DATE OF THIS ACT. OF THE TEN (10) MEMBERS APPOINTED BY THE GOVERNOR, THREE (3) SHALL SERVE A TERM OF ONE YEAR, THREE (3) SHALL SERVE A TERM OF TWO (2) YEARS, AND FOUR (4) SHALL SERVE A TERM OF THREE (3) YEARS. UPON EXPIRATION OF THE INITIAL TERM, COMMISSION MEMBERS SHALL SERVE TERMS OF THREE (3) YEARS. THE INITIAL TERMS OF COMMISSION MEMBERS SHALL BE DETERMINED BY LOT. <A]

2-12-20. Responsibility of director -- Traumatic brain injury. – It shall be the responsibility of the director of the department of human services to provide rehabilitative services for persons [D> suffering from <D]
[A> WITH <A] traumatic brain injury [D> . <D] [A> INCLUDING THE DEVELOPMENT OF INSTATE COMPREHENSIVE COMMUNITY-BASED SERVICES. <A]

[A> THE DEPARTMENT OF HUMAN SERVICES, IN CONSULTATION WITH THE PERMANENT ADVISORY COMMISSION ON TRAUMATIC BRAIN INJURIES, SHALL PROMULGATE SUCH RULES AND REGULATIONS IN ACCORDANCE WITH THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42, AS ARE NECESSARY

AND PROPER TO ENSURE RESPONSIBLE MANAGEMENT AND OPERATION OF SECTION 42-12-21.1. <A]

42-12-21. "Traumatic brain injury" defined. -- As used in this chapter, "traumatic brain injury" means an injury to the skull, the brain contents or its coverings, not of a degenerative or congenital nature, which may or may not produce an altered state of consciousness or result in temporary or permanent [D> anatomic <D] decrease of mental, cognitive, behavioral or physical functioning which causes partial or total disability.

SECTION 2. Chapter 42-12 of the General Laws entitled "Department of Human Services" is hereby amended by adding thereto the following section:

[A> 42-12-21.1. EXPENDITURES UNDER THE TRAUMATIC BRAIN INJURY PROGRAM. - EXPENDITURES OF THE ASSESSMENTS UNDER THE TRAUMATIC BRAIN INJURY PROGRAM SHALL BE FOR THE FOLLOWING PURPOSES: <A]

[A> (A) AS THE PAYOR OF LAST RESORT FOR INDIVIDUALS WHO HAVE EXHAUSTED ALL OTHER HEALTH OR REHABILITATION BENEFIT FUNDING SERVICES FOR SERVICES COVERED UNDER THIS SECTION. <A]

[A> (B) SERVICES INCLUDING, BUT NOT LIMITED TO: CASE MANAGEMENT; COGNITIVE REHABILITATION; TRANSITIONAL LIVING; STRUCTURED DAY PROGRAMS; ASSISTIVE TECHNOLOGY SERVICES; DEVICES AND EQUIPMENT; TRANSPORTATION; HOUSING; NEUROPSYCHOLOGICAL EVALUATIONS; BEHAVIORAL HEALTH TREATMENT; SUBSTANCE ABUSE TREATMENT; RESPITE; AND OTHER SERVICES AND/OR ASSISTANCE AS DEEMED APPROPRIATE BY THE COMMISSION FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY TO ACCOMPLISH A SUCCESSFUL RE-ENTRY AND MAINTENANCE IN THE COMMUNITY. <A]

[A> (C) GRANTS TO COMMUNITY-BASED PROGRAMS, PRIVATE PROVIDERS AND MUNICIPAL GOVERNMENTS FOR THE PURPOSE OF EXPANDING OR DEVELOPING SERVICES TARGETED FOR INDIVIDUALS WITH BRAIN INJURIES AS WELL AS FOR SYSTEM DEVELOPMENT AND MAINTENANCE. SUCH GRANTS SHALL BE AWARDED ONLY AFTER CONSULTATION WITH THE COMMISSION AND PURSUANT TO THE CRITERIA DEVELOPED JOINTLY BY THAT BODY, THE DEPARTMENT OF HUMAN SERVICES, THE DEPARTMENT OF HEALTH AND THE DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS. <A]

[A> (D) FUNDING FOR PUBLIC INFORMATION AND PREVENTION EDUCATION AND FOR THE CONTINUATION OF THE RESOURCE CENTER COORDINATED BY THE BRAIN INJURY ASSOCIATION OF RHODE ISLAND. <A]

SECTION 3. This act shall take effect upon passage.

SPONSOR: McNamara

EXPANDS SERVICE CAPACITY

THE STATE OF CONNECTICUT

CONNECTICUT GENERAL ASSEMBLY - JANUARY SESSION, 2005

HOUSE BILL 6646
PUBLIC ACT NO. 05-9

VERSION: Enrolled

VERSION-DATE: April 11, 2005

SYNOPSIS: AN ACT MAKING PERMANENT THE ACQUIRED OR TRAUMATIC BRAIN INJURY GROUP HOME PILOT PROGRAM.

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 17a-468b of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2005):

(b) Notwithstanding the provisions of chapters 368v and 368z, community-based organizations may operate residences for adult persons with acquired brain injuries [A> . <A] [D> on a pilot basis until October 1, 2005. <D] Notwithstanding the provisions of chapter 378, medication may be administered to persons residing in such residences by trained persons pursuant to the written order of a physician licensed under chapter 370, a dentist licensed under chapter 379, an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a, or a physician assistant licensed to prescribe in accordance with section 20-12d. The Commissioner of Public Health, in consultation with the Commissioner of Mental Health and Addiction Services, shall develop standards for the operation of such residences and the training required of persons authorized under this section to administer medications in such residences.

SPONSOR: Joint Committee on Public Health

THE STATE OF UTAH

UTAH 56TH LEGISLATURE -- 2005 GENERAL SESSION

H.B. 80 ENROLLED
SERVICES FOR PEOPLE WITH DISABILITIES
2005 GENERAL SESSION
STATE OF UTAH
CHIEF SPONSOR: REBECCA D. LOCKHART
SENATE SPONSOR: SHELDON L. KILLPACK

VERSION: Enacted

VERSION-DATE: March 11, 2005

SYNOPSIS: LONG TITLE

General Description:

This bill amends the portion of the Utah Human Services Code relating to services for people with disabilities and amends related provisions.

DIGEST:

Highlighted Provisions:

This bill:

-- defines terms;

-- removes all references to the obsolete voucher system for obtaining services;

-- describes when a person is eligible to receive services from the Division of Services for People with Disabilities;

-- establishes principles to be followed by the division when providing services to families who care for family members with disabilities; and

-- makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

62A-5-101, as last amended by Chapter 332, Laws of Utah 1996

62A-5-102, as last amended by Chapter 150, Laws of Utah 2003

62A-5-402, as last amended by Chapter 332, Laws of Utah 1996

63A-9-808.1, as enacted by Chapter 342, Laws of Utah 2004

77-16a-203, as last amended by Chapter 256, Laws of Utah 2000

77-16a-304, as last amended by Chapter 285, Laws of Utah 1993

REPEALS:

62A-5-301, as last amended by Chapter 114, Laws of Utah 2004

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: Be it enacted by the Legislature of the state of Utah:

Section 1. Section 62A-5-101 is amended to read:

62A-5-101. Definitions.

As used in this chapter:

[D> (8) <D] [A> (1) <A] "Approved provider" means a person who has been approved by the division to provide home-based services [D> and who has agreed to be compensated by voucher under Part 4 <D] .

[D> (1) <D] [A> (2) <A] "Board" means the Board of Services for People with Disabilities established in accordance with Section 62A-1-105.

[A> (3) (A) "BRAIN INJURY" MEANS AN ACQUIRED INJURY TO THE BRAIN THAT IS NEUROLOGICAL IN NATURE, INCLUDING A CEREBRAL VASCULAR ACCIDENT. <A]

[A> (B) "BRAIN INJURY" DOES NOT INCLUDE A DETERIORATING DISEASE. <A]

[A> (4) "DESIGNATED MENTAL RETARDATION PROFESSIONAL" MEANS: <A]

[A> (A) A PSYCHOLOGIST LICENSED UNDER TITLE 58, CHAPTER 61, WHO: <A]

[A> (I) (A) HAS AT LEAST ONE YEAR OF SPECIALIZED TRAINING IN WORKING WITH PERSONS WITH MENTAL RETARDATION; OR <A]

[A> (B) HAS AT LEAST ONE YEAR OF CLINICAL EXPERIENCE WITH PERSONS WITH MENTAL RETARDATION; AND <A]

[A> (II) IS DESIGNATED BY THE DIVISION AS SPECIALLY QUALIFIED, BY TRAINING AND EXPERIENCE, IN THE TREATMENT OF MENTAL RETARDATION; OR <A]

[A> (B) A CLINICAL OR CERTIFIED SOCIAL WORKER LICENSED UNDER TITLE 58, CHAPTER 60, MENTAL HEALTH PROFESSIONAL PRACTICE ACT, WHO: <A]

[A> (I) HAS AT LEAST TWO YEARS OF CLINICAL EXPERIENCE WITH PERSONS WITH MENTAL RETARDATION; AND <A]

[A> (II) IS DESIGNATED BY THE DIVISION AS SPECIALLY QUALIFIED, BY TRAINING AND EXPERIENCE, IN THE TREATMENT OF MENTAL RETARDATION. <A]

[A> (5) "DETERIORATING DISEASE" INCLUDES: <A]

[A> (A) MULTIPLE SCLEROSIS; <A]

[A> (B) MUSCULAR DYSTROPHY; <A]

[A> (C) HUNTINGTON'S CHOREA; <A]

[A> (D) ALZHEIMER'S DISEASE; <A]

[A> (E) ATAXIA; OR <A]

[A> (F) CANCER. <A]

[D> (2) <D] [A> (6) <A] "Developmental center" means the Utah State Developmental Center, established in accordance with Part 2 [D> of this chapter <D] [A> , UTAH STATE DEVELOPMENTAL CENTER <A] .

[D> (3) <D] [A> (7) <A] "Director" means the director of the Division of Services for People with Disabilities.

[D> (4) <D] [A> (8) <A] (a) "Disability" means a severe, chronic disability that:

(i) is attributable to [D> a mental or physical impairment or a combination of mental and physical impairments; <D] [A> : <A]

[A> (A) MENTAL RETARDATION; <A]

[A> (B) A CONDITION THAT QUALIFIES A PERSON AS A PERSON WITH A RELATED CONDITION, AS DEFINED IN 42 C.F.R. 435.1009; <A]

[A> (C) A BRAIN INJURY; OR <A]

[A> (D) A PHYSICAL DISABILITY; <A]

(ii) is likely to continue indefinitely;

(iii) results in a substantial functional limitation in three or more of the following areas of major

life activity:

(A) self-care;

(B) receptive and expressive language;

(C) learning;

(D) mobility;

(E) self-direction;

(F) capacity for independent living; or

(G) economic self-sufficiency; and

(iv) requires a combination or sequence of special interdisciplinary or generic care, treatment, or other services that [A> : <A]

[A> (A) <A] may continue throughout life [A> ; <A] and

[A> (B) <A] must be individually planned and coordinated.

[D> (b) For purposes of this chapter mental illness alone does not constitute a "disability." <D]

[A> (B) "DISABILITY" DOES NOT INCLUDE A CONDITION DUE SOLELY TO: <A]

[A> (I) MENTAL ILLNESS; <A]

[A> (II) PERSONALITY DISORDER; <A]

[A> (III) HEARING IMPAIRMENT; <A]

[A> (IV) VISUAL IMPAIRMENT; <A]

[A> (V) LEARNING DISABILITY; <A]

[A> (VI) BEHAVIOR DISORDER; <A]

[A> (VII) SUBSTANCE ABUSE; OR <A]

[A> (VIII) THE AGING PROCESS. <A]

[D> (5) <D] [A> (9) <A] "Division" means the Division of Services for People with Disabilities.

[A> (10) "ELIGIBLE TO RECEIVE DIVISION SERVICES" OR "ELIGIBILITY" MEANS QUALIFICATION, BASED ON CRITERIA ESTABLISHED BY THE DIVISION IN ACCORDANCE WITH SUBSECTION 62A-5-102 (3), TO RECEIVE SERVICES THAT ARE ADMINISTERED BY THE DIVISION. <A]

[A> (11) "LICENSED PHYSICIAN" MEANS: <A]

[A> (A) AN INDIVIDUAL LICENSED TO PRACTICE MEDICINE UNDER: <A]

[A> (I) TITLE 58, CHAPTER 67, UTAH MEDICAL PRACTICE ACT; OR <A]

[A> (II) TITLE 58, CHAPTER 68, UTAH OSTEOPATHIC MEDICAL PRACTICE ACT; OR <A]

[A> (B) A MEDICAL OFFICER OF THE UNITED STATES GOVERNMENT WHILE IN THIS STATE IN THE PERFORMANCE OF OFFICIAL DUTIES. <A]

[D> (6) <D] [A> (12) <A] "Mental retardation" means a significant, subaverage general intellectual functioning, [D> existing <D] [A> THAT: <A]

[A> (A) EXISTS <A] concurrently with deficits in adaptive behavior [D> , <D] [A> ; <A] and

[A> (B) IS <A] manifested during the developmental period as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

[D> (7) <D] [A> (13) <A] "Mental retardation facility" means a residential facility for [D> persons <D] [A> A PERSON <A] with mental retardation, that receives state or federal funds under Title XIX of the federal Social Security Act, for the purpose of serving [D> the population of <D] [A> A <A] mentally retarded [D> persons <D] [A> PERSON <A] in this state.

[A> (14) "PHYSICAL DISABILITY" MEANS A MEDICALLY DETERMINABLE PHYSICAL IMPAIRMENT THAT HAS RESULTED IN THE FUNCTIONAL LOSS OF TWO OR MORE OF A PERSON'S LIMBS. <A]

[A> (15) "RESIDENT" MEANS AN INDIVIDUAL UNDER OBSERVATION, CARE, OR TREATMENT IN A MENTAL RETARDATION FACILITY. <A]

[D> (9) "Voucher" means a document that: <D]

[D> (a) is issued by the division to a person with a disability or to his parent or guardian; <D]

[D> (b) describes the services and supports that may be received with the voucher; <D]

[D> (c) lists approved providers; <D]

[D> (d) may be used by a person with a disability or his parent or guardian to purchase services and supports from an approved provider; <D]

[D> (e) includes a maximum dollar value; <D]

[D> (f) states the period of time within which the voucher must be used by the person with a disability or his parent or guardian to purchase services and supports; and <D]

[D> (g) is redeemable by an approved provider for payment by the division up to the dollar value of the voucher. <D]

Section 2. Section 62A-5-102 is amended to read:

62A-5-102. Division of Services for People with Disabilities -- Creation -- Authority -- Direction -- Provision of services.

(1) There is created within the department the Division of Services for People with Disabilities, under the administrative direction of the executive director of the department.

(2) In accordance with this chapter, the division has the responsibility to plan and deliver an appropriate array of services and supports to persons with disabilities and their families in this state.

(3) Within appropriations from the Legislature, the division shall provide services to [D> persons with disabilities who are waiting for services and support from the division, based on the following criteria: <D] [A> ANY PERSON WITH A DISABILITY WHO IS ELIGIBLE TO RECEIVE DIVISION SERVICES. <A]

[A> (4) THE NEEDS OF A PERSON DESCRIBED IN SUBSECTION (3) SHALL BE EVALUATED BASED ON THE: <A]

(a) severity of [A> THE <A] disability;

(b) urgency of [A> THE <A] need for services;

[D> (c) length of time without services from the division, regardless of whether that person has formally applied for services and support from the division; and <D]

[D> (d) ability of parents or guardians to provide them with appropriate care and supervision. <D]

[A> (C) ABILITY OF A PARENT OR GUARDIAN TO PROVIDE THE PERSON WITH APPROPRIATE CARE AND SUPERVISION; AND <A]

[A> (D) LENGTH OF TIME DURING WHICH THE PERSON HAS NOT RECEIVED SERVICES FROM THE DIVISION. <A]

[D> (4) <D] [A> (5) <A] The division [A> : <A]

[A> (A) <A] has the functions, powers, duties, rights, and responsibilities described in Section 62A-5-103 [A> ; <A] and

[A> (B) <A] is authorized to work in cooperation with other state, governmental, and private agencies to carry out [D> those <D] [A> THE <A] responsibilities [A> DESCRIBED IN SUBSECTION (5)(A) <A] .

[D> (5) <D] [A> (6) <A] Within appropriations authorized by the Legislature, and to the extent allowed under Title XIX of the Social Security Act, the division shall ensure that the services and support [D> it <D] [A> THAT THE DIVISION <A] provides to [D> persons with disabilities <D] [A> ANY PERSON WITH A DISABILITY <A] :

(a) are provided in the least restrictive and most enabling environment;

(b) ensure opportunities to access employment; and

(c) enable reasonable personal choice in selecting services and support that [A> : <A]

[A> (I) <A] best meet individual needs [A> ; <A] and

[A> (II) <A] promote [A> : <A]

[A> (A) <A] independence [D> , <D] [A> ; <A]

[A> (B) <A] productivity [D> , <D] [A> ; <A] and

[A> (C) <A] integration in community life.

[D> (6) <D] [A> (7) (A) <A] Appropriations to the division are nonlapsing.

[A> (B) <A] Funds unexpended [A> BY THE DIVISION <A] at the end of the fiscal year may be used only for one-time expenditures unless otherwise authorized by the Legislature.

Section 3. Section 62A-5-402 is amended to read:

62A-5-402. Scope of services -- Principles.

(1) (a) To enable a person with a disability and [D> his <D] [A> THE PERSON'S <A] family to select services and supports that best suit their needs and preferences, the division shall, within appropriations from the Legislature, provide services and supports under this part by giving [D> vouchers or <D] direct financial assistance to the parent or guardian of a person with a disability who resides at home.

(b) The dollar value of [D> a voucher or <D] direct financial assistance is determined by the division based on [A> : <A]

[A> (I) <A] appropriations from the Legislature [A> ; <A] and

[A> (II) <A] the needs of the person with a disability.

(c) In determining whether to provide [D> either a voucher or <D] direct financial assistance to the family, the division shall consider:

(i) the family's preference; and

(ii) the availability of [D> qualified <D] [A> APPROVED <A] providers in the area where the family resides.

(d) If the division provides direct financial assistance, [D> it <D] [A> THE DIVISION: <A]

[A> (I) <A] [D> may <D] [A> SHALL <A] require the family to account for the use of that financial assistance [D> . <D] [A> ; AND <A]

[D> (e) When the division provides a voucher or direct financial assistance, the division <D]

[A> (II) <A] shall tell the person with a disability or [D> his <D] [A> THE PERSON'S <A] parent or guardian how long the [D> voucher or <D] direct financial assistance is intended to provide services and supports before [D> the next voucher or <D] [A> ADDITIONAL <A] direct financial assistance is issued.

[D> (f) <D] [A> (E) <A] Except for eligibility determination services directly connected to the provision of [D> the voucher or <D] direct financial assistance, service coordination is not provided under this part by the division unless the person with a disability or [D> his <D] [A> THE PERSON'S <A] parent or guardian uses the [D> voucher or <D] direct financial assistance to purchase such services.

[D> (g) A voucher may only be redeemed with a qualified provider. <D]

(2) The following principles shall be used as the basis for supporting families who care for family members with disabilities:

(a) all children, regardless of disability, should reside in a family-like environment;

(b) families should receive the support they need to care for their children at home;

(c) services should [A> : <A]

[A> (I) <A] focus on the person with a disability [D> but should also consider the entire family <D] ;

[A> (II) TAKE INTO CONSIDERATION THE FAMILY OF THE PERSON DESCRIBED IN SUBSECTION (2)(C)(I); <A]

[D> (d) services should <D] [A> (III) <A] be sensitive to the unique needs, preferences, and strengths of individual families; and

[D> (e) services should <D] [A> (IV) <A] complement and reinforce existing sources of help and support that are available to each family.

Section 4. Section 63A-9-808.1 is amended to read:

63A-9-808.1. Transfer of information technology equipment for persons with a disability.

(1) As used in this section, " [D> persons <D] [A> A PERSON <A] with a disability" means [D> persons who meet the criteria in Subsections 62A-5-101 (4)(a)(i) and (ii). <D] [A> A PERSON WITH A SEVERE, CHRONIC DISABILITY THAT: <A]

[A> (A) IS ATTRIBUTABLE TO A MENTAL OR PHYSICAL IMPAIRMENT OR A COMBINATION OF MENTAL AND PHYSICAL IMPAIRMENTS; AND <A]

[A> (B) IS LIKELY TO CONTINUE INDEFINITELY. <A]

(2) The division may transfer information technology equipment, or authorize the transfer of technology equipment by an agency, to a nonprofit entity for distribution to and use by [D> persons <D] [A> A PERSON <A] with a disability.

(3) Interagency transfers and sales of surplus property to state and local agencies within the 30-day period under Section 63A-9-808 shall have priority over transfers under Subsection (2).

(4) The division shall annually report to the Division of Services for People With Disabilities the [A> : <A]

[A> (A) <A] names of the nonprofit entities receiving transfers under Subsection (2) [A> ; <A] and [D> the <D]

[A> (B) <A] types and amounts of equipment received.

Section 5. Section 77-16a-203 is amended to read:

77-16a-203. Review of offenders with a mental illness committed to department -- Recommendations for transfer to Department of Corrections.

(1) [A> (A) <A] The executive director shall designate a review team of at least three qualified staff members, including at least one licensed psychiatrist, to evaluate the mental condition of each mentally ill offender committed to it in accordance with Section 77-16a-202, at least once every six months.

[A> (B) <A] If the offender is mentally retarded, the review team shall include at least one individual who is a designated mental retardation professional, as defined in Section [D> 62A-5-301 <D] [A> 62A-5-101 <A] .

(2) At the conclusion of its evaluation, the review team described in Subsection (1) shall make a report to the executive director [A> : <A]

[A> (A) <A] regarding the offender's [A> : <A]

[A> (I) <A] current mental condition [D> , his <D] [A> ; <A]

[A> (II) <A] progress since commitment [D> , <D] [A> ; AND <A]

[A> (III) <A] prognosis [D> , <D] [A> ; <A] and

[A> (B) THAT INCLUDES <A] a recommendation regarding whether the mentally ill offender should be [A> : <A]

[A> (I) <A] transferred to UDC [A> ; <A] or

[A> (II) <A] remain in the custody of the department.

(3) (a) The executive director shall notify the UDC medical administrator, and the board's mental health adviser that a mentally ill offender is eligible for transfer to UDC if the review team finds that the offender:

(i) is no longer mentally ill; or

(ii) is still mentally ill and may continue to be a danger to himself or others, but can be controlled

if adequate care, medication, and treatment are provided by UDC; and

(iii) the offender's condition has been stabilized to the point that commitment to the department and admission to the Utah State Hospital are no longer necessary to ensure adequate mental health treatment.

(b) The administrator of the mental health facility where the offender is located shall provide the UDC medical administrator with a copy of the reviewing staff's recommendation and:

(i) all available clinical facts;

(ii) the diagnosis;

(iii) the course of treatment received at the mental health facility;

(iv) the prognosis for remission of symptoms;

(v) the potential for recidivism;

(vi) an estimation of the offender's dangerousness, either to himself or others; and

(vii) recommendations for future treatment.

Section 6. Section 77-16a-304 is amended to read:

77-16a-304. Review after commitment.

(1) [A> (A) <A] The executive director, or [D> his <D] [A> THE EXECUTIVE DIRECTOR'S <A] designee, shall establish a review team of at least three qualified staff members to review the defendant's mental condition at least every six months. [D> That team <D]

[A> (B) THE TEAM DESCRIBED IN SUBSECTION (1)(A) <A] shall include [A> : <A]

[A> (I) <A] at least one psychiatrist [A> ; <A] and [D> , <D]

[A> (II) <A] if the defendant is mentally retarded, at least one staff member who is a designated mental retardation professional, as defined in Section [D> 62A-5-301 <D] [A> 62A-5-101 <A] .

(2) If the review team described in Subsection (1) finds that the defendant has recovered from [D> his <D] [A> THE DEFENDANT'S <A] mental illness, or, that the defendant is still mentally ill but does not present a substantial danger to himself or others, the executive director, or [D> his <D] [A> THE EXECUTIVE DIRECTOR'S <A] designee, shall [A> : <A]

[A> (A) <A] notify the court that committed the defendant that the defendant is a candidate for discharge [A> ; <A] and [D> shall <D]

[A> (B) <A] provide the court with a report stating the facts that form the basis for the recommendation.

(3) [A> (A) <A] The court shall conduct a hearing within ten business days after receipt of the executive director's, or [D> his <D] [A> THE EXECUTIVE DIRECTOR'S <A] designee's,

notification.

[A> (B) <A] The court clerk shall [D> notify <D] [A> PROVIDE NOTICE OF THE DATE AND TIME OF THE HEARING TO: <A]

[A> (I) <A] the prosecuting attorney [D> , <D] [A> ; <A]

[A> (II) <A] the defendant's attorney [D> , <D] [A> ; <A] and

[A> (III) <A] any victim of the crime for which the defendant was found not guilty by reason of insanity [D> , of the date and time of hearing <D] .

(4) (a) [D> If <D] [A> THE COURT SHALL ORDER THAT THE DEFENDANT BE DISCHARGED FROM COMMITMENT IF <A] the court finds that the [D> person <D] [A> DEFENDANT: <A]

[A> (I) <A] is no longer mentally ill [D> , <D] [A> ; <A] or [D> if <D]

[A> (II) IS <A] mentally ill, [A> BUT <A] no longer presents a substantial danger to himself or others [D> , it shall order the defendant to be discharged from commitment <D] .

(b) [D> If <D] [A> THE COURT SHALL ORDER THE PERSON CONDITIONALLY RELEASED IN ACCORDANCE WITH SECTION 77-16A-305 IF <A] the court finds that the [D> person <D] [A> DEFENDANT: <A]

[A> (I) <A] is still mentally ill [D> and <D] [A> ; <A]

[A> (II) <A] is a substantial danger to himself or others [D> , but <D] [A> ; AND <A]

[A> (III) <A] can be controlled adequately if conditionally released with treatment as a condition of release [D> , it shall order the person conditionally released in accordance with Section 77-16a-305 <D] .

(c) [D> If <D] [A> THE COURT SHALL ORDER THAT THE COMMITMENT BE CONTINUED IF <A] the court finds that the defendant [A> : <A]

[A> (I) <A] has not recovered from his mental illness [D> and <D] [A> ; <A]

[A> (II) <A] is a substantial danger to himself or others [A> ; <A] and

[A> (III) <A] cannot adequately be controlled if conditionally released on supervision [D> , the court shall order that the commitment be continued <D] .

(d) [D> The <D] [A> (I) EXCEPT AS PROVIDED IN SUBSECTION (4)(D)(II), THE <A] court may not discharge [D> an individual <D] [A> A DEFENDANT <A] whose mental illness is in remission as a result of medication or hospitalization if it can be determined within reasonable medical probability that without continued medication or hospitalization the defendant's mental illness will reoccur, making [D> him <D] [A> THE DEFENDANT <A] a substantial danger to himself or others. [D> That person may, however, <D]

[A> (II) NOTWITHSTANDING SUBSECTION (4)(D)(I), THE DEFENDANT DESCRIBED IN

SUBSECTION (4)(D)(I) MAY <A] be a candidate for conditional release, in accordance with Section 77-16a-305.

Section 7. Repealer.

This bill repeals:

Section 62A-5-301, Definitions.

SPONSOR: Lockhart

THE STATE OF UTAH

UTAH 56TH LEGISLATURE -- 2006 GENERAL SESSION

HOUSE BILL 213

H.B. 213 ENROLLED
SERVICES FOR PEOPLE WITH BRAIN INJURIES
2006 GENERAL SESSION
STATE OF UTAH
CHIEF SPONSOR: RONDA RUDD MENLOVE
SENATE SPONSOR: SHELDON L. KILLPACK

VERSION: Enacted

VERSION-DATE: March 20, 2006

SYNOPSIS: LONG TITLE

General Description:

This bill amends the definition of a disability within the Services for People with Disabilities chapter of the Utah Human Services Code.

DIGEST:

Highlighted Provisions:

This bill:
amends the definition of a disability within the Services for People with Disabilities chapter of the Utah Human Services Code as it relates to a brain injury; and makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

62A-5-101, as last amended by Chapters 60 and 61, Laws of Utah 2005

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: Be it enacted by the Legislature of the state of Utah:

Section 1. Section 62A-5-101 is amended to read:

62A-5-101. Definitions.

As used in this chapter:

(1) "Approved provider" means a person approved by the division to provide home-based services.

(2) "Board" means the Board of Services for People with Disabilities established in accordance with Section 62A-1-105.

(3) (a**) "**Brain injury**"** means an acquired injury to the brain that is neurological in nature, including a cerebral vascular accident.

(b) **"**Brain injury**"** does not include a deteriorating disease.

(4) "Designated mental retardation professional" means:

(a) a psychologist licensed under Title 58, Chapter 61, [A> PSYCHOLOGIST LICENSING ACT, <A] who:

(i) (A) has at least one year of specialized training in working with persons with mental retardation; or

(B) has at least one year of clinical experience with persons with mental retardation; and

(ii) is designated by the division as specially qualified, by training and experience, in the treatment of mental retardation; or

(b) a clinical or certified social worker licensed under Title 58, Chapter 60, Mental Health Professional Practice Act, who:

(i) has at least two years of clinical experience with persons with mental retardation; and

(ii) is designated by the division as specially qualified, by training and experience, in the treatment of mental retardation.

(5) "Deteriorating disease" includes:

(a) multiple sclerosis;

(b) muscular dystrophy;

(c) Huntington's chorea;

(d) Alzheimer's disease;

(e) ataxia; or

(f) cancer.

(6) "Developmental center" means the Utah State Developmental Center, established in accordance with Part 2, Utah State Developmental Center.

(7) "Direct service worker" means a person who provides services to a person with a disability:

(a) when the services are rendered in:

(i) the physical presence of the person with a disability; or

(ii) a location where the person rendering the services has access to the physical presence of the person with a disability; and

(b) under:

(i) a contract with the division; or

(ii) a grant agreement with the division.

(8) "Director" means the director of the Division of Services for People with Disabilities.

(9) (a) "Disability" means a severe, chronic disability that:

(i) is attributable to:

(A) mental retardation;

(B) a condition that qualifies a person as a person with a related condition, as defined in 42 C.F.R. 435.1009;

[D> (C) a brain injury; or <D]

[D> (D) <D] [A> (C) <A] a physical disability; [A> OR <A]

[A> (D) A BRAIN INJURY; <A]

(ii) is likely to continue indefinitely;

(iii) [A> (A) FOR A CONDITION DESCRIBED IN SUBSECTION (9)(A)(I)(A), (B), OR (C), <A] results in a substantial functional limitation in three or more of the following areas of major life activity:

[D> (A) <D] [A> (I) <A] self-care;

[D> (B) <D] [A> (II) <A] receptive and expressive language;

[D> (C) <D] [A> (III) <A] learning;

[D> (D) <D] [A> (IV) <A] mobility;

[D> (E) <D] [A> (V) <A] self-direction;

[D> (F) <D] [A> (VI) <A] capacity for independent living; or

[D> (G) <D] [A> (VII) <A] economic self-sufficiency; [D> and <D] [A> OR <A]

[A> (B) FOR A CONDITION DESCRIBED IN SUBSECTION (9)(A)(I)(D), RESULTS IN A SUBSTANTIAL LIMITATION IN THREE OR MORE OF THE FOLLOWING AREAS: <A]

[A> (I) MEMORY OR COGNITION; <A]

[A> (II) ACTIVITIES OF DAILY LIFE; <A]

[A> (III) JUDGMENT AND SELF-PROTECTION; <A]

[A> (IV) CONTROL OF EMOTIONS; <A]

[A> (V) COMMUNICATION; <A]

[A> (VI) PHYSICAL HEALTH; OR <A]

[A> (VII) EMPLOYMENT; AND <A]

(iv) requires a combination or sequence of special interdisciplinary or generic care, treatment, or other services that:

(A) may continue throughout life; and

(B) must be individually planned and coordinated.

(b) "Disability" does not include a condition due solely to:

(i) mental illness;

(ii) personality disorder;

(iii) hearing impairment;

(iv) visual impairment;

(v) learning disability;

(vi) behavior disorder;

(vii) substance abuse; or

(viii) the aging process.

(10) "Division" means the Division of Services for People with Disabilities.

(11) "Eligible to receive division services" or "eligibility" means qualification, based on criteria established by the division in accordance with Subsection 62A-5-102 [D> (3) <D] [A> (4) <A] , to receive services that are administered by the division.

(12) "Endorsed program" means a facility or program that:

(a) is operated:

(i) by the division; or

(ii) under contract with the division; or

(b) provides services to a person committed to the division under Part 3, Admission to Mental Retardation Facility.

(13) "Licensed physician" means:

(a) an individual licensed to practice medicine under:

(i) Title 58, Chapter 67, Utah Medical Practice Act; or

(ii) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; or

(b) a medical officer of the United States Government while in this state in the performance of official duties.

(14) "Mental retardation" means a significant, subaverage general intellectual functioning, that:

(a) exists concurrently with deficits in adaptive behavior; and

(b) is manifested during the developmental period as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(15) "Mental retardation facility" means a residential facility for a person with mental retardation, that receives state or federal funds under Title XIX of the federal Social Security Act, for the purpose of serving a mentally retarded person in this state.

(16) "Physical disability" means a medically determinable physical impairment that has resulted in the functional loss of two or more of a person's limbs.

(17) "Public funds" means state or federal funds that are disbursed by the division.

(18) "Resident" means an individual under observation, care, or treatment in a mental retardation facility.

SPONSOR: Menlove

FUNDING FOR TBI SERVICES

THE STATE OF NEW MEXICO

NEW MEXICO 47TH LEGISLATURE - FIRST REGULAR SESSION

HOUSE BILL 318

VERSION: Enacted - Interim

VERSION-DATE: April 6, 2005

SYNOPSIS:

AN ACT

RELATING TO MEDICAID; AUTHORIZING SERVICES TO SUPPORT INDIVIDUALS WITH BRAIN INJURIES; MAKING AN APPROPRIATION; DECLARING AN EMERGENCY.

TEXT: BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. A new section of the Public Assistance Act is enacted to read:

"BRAIN INJURY-- SERVICES AUTHORIZED.--Subject to the availability of state funds and consistent with Title 19 of the federal Social Security Act, the department shall provide services to persons with brain injuries, with emphasis on long-term disability services provided through home- and community-based programs."

Section 2. APPROPRIATION.--Two million dollars ($ 2,000,000) is appropriated from the general fund to the aging and long-term services department for expenditure in fiscal years 2005 and 2006, in cooperation with the human services department, to provide services to persons with brain injuries with emphasis on long-term disability services provided through home- and community-based programs. Any unexpended or unencumbered balance remaining at the end of fiscal year 2006 shall revert to the general fund.

Section 3. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

SPONSOR: Beam

THE STATE OF MONTANA

MONTANA 59TH REGULAR SESSION

SENATE BILL 127

INTRODUCED BY KEENAN
BY REQUEST OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

VERSION: Enacted

VERSION-DATE: April 21, 2005

SYNOPSIS: AN ACT FACILITATING THE IMPLEMENTATION OF CERTAIN RECOMMENDATIONS OF THE MONTANA PUBLIC HEALTH CARE REDESIGN PROJECT REGARDING PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES FUNDED WITH MEDICAID MONEY; REVISING THE STATUTES AUTHORIZING PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FUNDED WITH MEDICAID MONEY; AUTHORIZING THE LONG-TERM CARE PREADMISSION SCREENING PROCESS; REMOVING AN INAPPROPRIATE APPLICATION OF MEDICAID STATE PLAN AUTHORITY TO THE PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES AND A REQUIREMENT FOR REPORTING COSTS OF PROVIDING HOME AND COMMUNITY-BASED SERVICES TO PERSONS CURRENTLY LIVING IN ASSISTED LIVING FACILITIES; AMENDING SECTIONS 53-6-101, 53-6-401, AND 53-6-402, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. [D> , as may be amended. <D] The department [D> of public health and human services <D] shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department; and

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) services of psychologists licensed under Title 37, chapter 17;

(p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

(q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) Services for persons qualifying for medicaid under the medically needy category of assistance as described in 53-6-131 may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (2) and (3) to persons qualifying for medicaid under the medically needy category of assistance.

(5) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department [D> of public health and human services <D] may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsections (2)(a) through (2)(l) but may include those optional services listed in subsections (3)(a) through (3)(q) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(6) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(7) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(8) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(9) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(10) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(11) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

[D> (12) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted under this chapter. <D]

[D> (13) Medicaid payment for assisted living facilities may not be made unless the department certifies to the director of the governor's office of budget and program planning that payment to this type of provider would, in the aggregate, be a cost-effective alternative to services otherwise provided. <D] "

Section 2. Section 53-6-401, MCA, is amended to read:

"53-6-401. Definitions. As used in this part, the following definitions apply:

[D> (1) "Community-based medicaid services" means those long-term medical, habilitative, rehabilitative, and other services that are available to medicaid-eligible persons in a community setting or in a person's home as a substitute for medicaid services provided in long-term care facilities and that are allowed under the state medicaid plan in order to avoid institutionalization. <D]

[D> (2) <D] [A> (1) <A] "Department" means the department of public health and human services provided for in 2-15-2201.

[A> (2) "HOME AND COMMUNITY-BASED SERVICES" MEANS, AS PROVIDED FOR IN SECTION 1915 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396N, AND REGULATIONS IMPLEMENTING THAT STATUTE, LONG-TERM MEDICAL, HABILITATIVE, REHABILITATIVE, AND OTHER SERVICES PROVIDED IN PERSONAL RESIDENCES OR IN COMMUNITY SETTINGS AND FUNDED BY THE DEPARTMENT WITH MEDICAID MONEY. <A]

[A> (3) "LEVEL-OF-CARE DETERMINATION" MEANS AN ASSESSMENT OF A PERSON AND THE RESULTING DETERMINATION ESTABLISHING WHETHER LONG-TERM CARE FACILITY SERVICES TO BE PROVIDED TO THE PERSON ARE APPROPRIATE TO MEET THE HEALTH CARE AND RELATED CIRCUMSTANCES AND NEEDS OF THE PERSON. <A]

[D> (3) <D] [A> (4) <A] "Long-term care [D> facilities <D] [A> FACILITY <A] " means [D> facilities <D] [A> A FACILITY <A] that [D> are <D] [A> IS <A] certified by the department [A> , AS PROVIDED IN 53-6-106, <A] to provide skilled or intermediate nursing care services, including intermediate nursing care services for persons with developmental disabilities [A> OR, FOR THE PURPOSES OF IMPLEMENTATION OF MEDICAID-FUNDED PROGRAMS OF

HOME AND COMMUNITY-BASED SERVICES, THAT IS RECOGNIZED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES TO BE AN INSTITUTIONAL SETTING FROM WHICH PERSONS MAY BE DIVERTED THROUGH THE RECEIPT OF HOME AND COMMUNITY-BASED SERVICES <A] .

[D> (4) "Long-term care medicaid services" means community-based medicaid services and those medicaid services provided in long-term care facilities. <D]

[D> (5) <D] [A> (5) <A] "Long-term care preadmission screening [D> and resident review <D] " means [A> , <A] [D> an evaluation that results in a determination as to <D] [A> IN ACCORDANCE WITH SECTION 1919 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396R, A PROCESS CONDUCTED ACCORDING TO A SPECIFIC SET OF CRITERIA FOR DETERMINING <A] whether a person [D> requires the services provided in long-term care facilities and whether community-based medicaid services would be an appropriate substitute for medicaid services that are available in long-term care facilities <D] [A> WITH MENTAL RETARDATION OR MENTAL ILLNESS MAY BE ADMITTED TO A LONG-TERM CARE FACILITY <A] .

[A> (6) "PERSONS WITH DISABILITIES OR PERSONS WHO ARE ELDERLY" MEANS, FOR PURPOSES OF ESTABLISHING HOME AND COMMUNITY-BASED SERVICES, THOSE CATEGORIES OF PERSONS WHO ARE ELDERLY AND DISABLED AS DEFINED IN ACCORDANCE WITH SECTION 1915 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396N. <A] "

Section 3. Section 53-6-402, MCA, is amended to read:

"53-6-402. [D> Community-based <D] [A> MEDICAID-FUNDED HOME AND COMMUNITY-BASED SERVICES -- WAIVERS -- FUNDING LIMITATIONS -- POPULATIONS -- SERVICES -- PROVIDERS -- <A] long-term care [D> facilities <D] [A> PREADMISSION SCREENING <A] -- powers and duties of department [A> -- RULEMAKING AUTHORITY <A] . (1) The department may [D> operate, for persons eligible for medicaid**,** a program of <D] [A> OBTAIN WAIVERS OF FEDERAL MEDICAID LAW IN ACCORDANCE WITH SECTION 1915 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396N, AND ADMINISTER PROGRAMS OF HOME AND <A] community-based services [D> as an alternative to long-term care facility services in accordance with the provisions of Title XIX of the Social Security Act, as may be amended <D] [A> FUNDED WITH MEDICAID MONEY FOR CATEGORIES OF PERSONS WITH
DISABILITIES OR PERSONS WHO ARE ELDERLY <A] .

[A> (2) THE DEPARTMENT MAY, SUBJECT TO THE TERMS AND CONDITIONS OF A FEDERAL WAIVER OF LAW, ADMINISTER PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES TO SERVE PERSONS WITH DISABILITIES OR PERSONS WHO ARE ELDERLY WHO MEET THE LEVEL OF CARE REQUIREMENTS FOR ONE OF THE CATEGORIES OF LONG-TERM CARE SERVICES THAT MAY BE FUNDED WITH MEDICAID MONEY. PERSONS WITH DISABILITIES INCLUDE PERSONS WITH PHYSICAL DISABILITIES, CHRONIC MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, BRAIN INJURY, OR OTHER CHARACTERISTICS AND NEEDS RECOGNIZED AS APPROPRIATE POPULATIONS BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. PROGRAMS MAY SERVE COMBINATIONS OF POPULATIONS AND SUBSETS OF POPULATIONS THAT ARE APPROPRIATE SUBJECTS FOR A PARTICULAR PROGRAM OF SERVICES. <A]

[A> (3) THE PROVISION OF SERVICES TO A SPECIFIC POPULATION THROUGH A HOME AND COMMUNITY-BASED SERVICES PROGRAM MUST BE LESS COSTLY IN TOTAL MEDICAID FUNDING THAN SERVING THAT POPULATION THROUGH THE CATEGORIES OF LONG-TERM CARE FACILITY SERVICES THAT THE SPECIFIC POPULATION WOULD BE ELIGIBLE TO RECEIVE OTHERWISE. <A]

[A> (4) THE DEPARTMENT MAY INITIATE AND OPERATE A HOME AND COMMUNITY-BASED SERVICES PROGRAM TO MORE EFFICIENTLY APPLY AVAILABLE STATE GENERAL FUND MONEY, OTHER AVAILABLE STATE AND LOCAL PUBLIC AND PRIVATE MONEY, AND FEDERAL MONEY TO THE DEVELOPMENT AND MAINTENANCE OF MEDICAID-FUNDED PROGRAMS OF HEALTH CARE AND RELATED SERVICES AND TO STRUCTURE THOSE PROGRAMS FOR MORE EFFICIENT AND EFFECTIVE DELIVERY TO SPECIFIC POPULATIONS. <A]

[A> (5) THE DEPARTMENT, IN ESTABLISHING PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES, SHALL ADMINISTER THE EXPENDITURES FOR EACH PROGRAM WITHIN THE AVAILABLE STATE SPENDING AUTHORITY THAT MAY BE APPLIED TO THAT PROGRAM. IN ESTABLISHING COVERED SERVICES FOR A HOME AND COMMUNITY-BASED SERVICES PROGRAM, THE DEPARTMENT SHALL ESTABLISH THOSE SERVICES IN A MANNER TO ENSURE THAT THE RESULTING EXPENDITURES REMAIN WITHIN THE AVAILABLE FUNDING FOR THAT PROGRAM. TO THE EXTENT PERMITTED UNDER FEDERAL LAW, THE DEPARTMENT MAY ADOPT FINANCIAL PARTICIPATION REQUIREMENTS FOR ENROLLEES IN A HOME AND COMMUNITY-BASED SERVICES PROGRAM TO FOSTER APPROPRIATE UTILIZATION OF SERVICES AMONG ENROLLEES AND TO MAINTAIN FISCAL ACCOUNTABILITY OF THE PROGRAM. THE DEPARTMENT MAY ADOPT FINANCIAL PARTICIPATION REQUIREMENTS THAT MAY INCLUDE BUT ARE NOT LIMITED TO COPAYMENTS, PAYMENT OF MONTHLY OR YEARLY ENROLLMENT FEES, OR DEDUCTIBLES. THE FINANCIAL PARTICIPATION REQUIREMENTS ADOPTED BY THE DEPARTMENT MAY VARY AMONG THE VARIOUS HOME AND COMMUNITY-BASED SERVICES PROGRAMS. THE DEPARTMENT, AS NECESSARY, MAY FURTHER LIMIT ENROLLMENT IN PROGRAMS, REDUCE THE PER CAPITA EXPENDITURES AVAILABLE TO ENROLLEES, AND MODIFY AND REDUCE THE TYPES AND AMOUNTS OF SERVICES AVAILABLE THROUGH A HOME AND COMMUNITY-BASED SERVICES PROGRAM WHEN THE DEPARTMENT DETERMINES THAT EXPENDITURES FOR A PROGRAM ARE REASONABLY EXPECTED TO EXCEED THE AVAILABLE SPENDING AUTHORITY. <A]

[A> (6) THE DEPARTMENT MAY CONSIDER THE FOLLOWING POPULATIONS OR SUBSETS OF POPULATIONS FOR HOME AND COMMUNITY-BASED SERVICES PROGRAMS: <A]

[A> (A) PERSONS WITH DEVELOPMENTAL DISABILITIES WHO NEED, ON AN ONGOING OR FREQUENT BASIS, HABILITATIVE AND OTHER SPECIALIZED AND SUPPORTIVE DEVELOPMENTAL DISABILITIES SERVICES TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN COMMUNITY-INTEGRATED RESIDENTIAL AND DAY OR WORK SITUATIONS; <A]

[A> (B) PERSONS WITH DEVELOPMENTAL DISABILITIES WHO ARE 18 YEARS OF AGE AND OLDER AND WHO ARE IN NEED OF HABILITATIVE AND OTHER SPECIALIZED AND SUPPORTIVE DEVELOPMENTAL DISABILITIES SERVICES NECESSARY TO MAINTAIN

THE PERSONS IN PERSONAL RESIDENTIAL SITUATIONS AND IN INTEGRATED WORK OPPORTUNITIES; <A]

[A> (C) PERSONS 18 YEARS OF AGE AND OLDER WITH DEVELOPMENTAL DISABILITIES AND CHRONIC MENTAL ILLNESS WHO ARE IN NEED OF MENTAL HEALTH SERVICES IN ADDITION TO HABILITATIVE AND OTHER DEVELOPMENTAL DISABILITIES SERVICES NECESSARY TO MEET THEIR NEEDS OF DAILY LIVING, TO TREAT THE THEIR MENTAL ILLNESS, AND TO MAINTAIN THE PERSONS IN COMMUNITY-INTEGRATED RESIDENTIAL AND DAY OR WORK SITUATIONS; <A]

[A> (D) CHILDREN UNDER 21 YEARS OF AGE WHO ARE SERIOUSLY EMOTIONALLY DISTURBED AND IN NEED OF MENTAL HEALTH AND OTHER SPECIALIZED AND SUPPORTIVE SERVICES TO TREAT THEIR MENTAL ILLNESS AND TO MAINTAIN THE CHILDREN WITH THEIR FAMILIES OR IN OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS; <A]

[A> (E) PERSONS 18 YEARS OF AGE AND OLDER WITH BRAIN INJURIES WHO ARE IN NEED, ON AN ONGOING OR FREQUENT BASIS, OF HABILITATIVE AND OTHER SPECIALIZED AND SUPPORTIVE SERVICES TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS; <A]

[A> (F) PERSONS 18 YEARS OF AGE AND OLDER WITH PHYSICAL DISABILITIES WHO ARE IN NEED, ON AN ONGOING OR FREQUENT BASIS, OF SPECIALIZED HEALTH SERVICES AND PERSONAL ASSISTANCE AND OTHER SUPPORTIVE SERVICES NECESSARY TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS; <A]

[A> (G) PERSONS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION WHO ARE IN NEED OF SPECIALIZED HEALTH SERVICES AND INTENSIVE PHARMACEUTICAL THERAPEUTIC REGIMENS FOR ABATEMENT AND CONTROL OF THE HIV INFECTION AND RELATED SYMPTOMS IN ORDER TO MAINTAIN THE PERSONS IN PERSONAL RESIDENTIAL SITUATIONS; <A]

[A> (H) PERSONS WITH CHRONIC MENTAL ILLNESS WHO SUFFER FROM SERIOUS CHEMICAL DEPENDENCY AND WHO ARE IN NEED OF INTENSIVE MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS; <A]

[A> (I) PERSONS 65 YEARS OF AGE AND OLDER WHO ARE IN NEED, ON AN ONGOING OR FREQUENT BASIS, OF HEALTH SERVICES, PERSONAL ASSISTANCE, AND OTHER SUPPORTIVE SERVICES NECESSARY TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS; OR <A]

[A> (J) PERSONS 18 YEARS OF AGE AND OLDER WITH CHRONIC MENTAL ILLNESS WHO ARE IN NEED, ON AN ONGOING OR FREQUENT BASIS, OF SPECIALIZED HEALTH SERVICES AND OTHER SUPPORTIVE SERVICES NECESSARY TO MEET THEIR NEEDS OF DAILY LIVING AND TO MAINTAIN THE PERSONS IN PERSONAL OR OTHER COMMUNITY-INTEGRATED RESIDENTIAL SITUATIONS. <A]

[A> (7) FOR EACH AUTHORIZED PROGRAM OF HOME AND COMMUNITY-BASED SERVICES, THE DEPARTMENT SHALL SET LIMITS ON OVERALL EXPENDITURES AND ENROLLMENT AND LIMIT EXPENDITURES AS NECESSARY TO CONFORM WITH THE REQUIREMENTS OF SECTION 1915 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396N, AND THE CONDITIONS PLACED UPON APPROVAL OF A PROGRAM AUTHORIZED THROUGH A WAIVER OF FEDERAL LAW BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. <A]

[A> (8) A HOME AND COMMUNITY-BASED SERVICES PROGRAM MAY INCLUDE ANY OF THE FOLLOWING CATEGORIES OF SERVICES AS DETERMINED BY THE DEPARTMENT TO BE APPROPRIATE FOR THE POPULATION OR POPULATIONS TO BE SERVED AND AS APPROVED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES: <A]

[A> (A) CASE MANAGEMENT SERVICES; <A]

[A> (B) HOMEMAKER SERVICES; <A]

[A> (C) HOME HEALTH AIDE SERVICES; <A]

[A> (D) PERSONAL CARE SERVICES; <A]

[A> (E) ADULT DAY HEALTH SERVICES; <A]

[A> (F) HABILITATION SERVICES; <A]

[A> (G) RESPITE CARE SERVICES; AND <A]

[A> (H) OTHER COST-EFFECTIVE SERVICES APPROPRIATE FOR MAINTAINING THE HEALTH AND WELL-BEING OF PERSONS AND TO AVOID INSTITUTIONALIZATION OF PERSONS. <A]

[A> (9) SUBJECT TO THE APPROVAL OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE DEPARTMENT MAY ESTABLISH APPROPRIATE PROGRAMS OF HOME AND COMMUNITY-BASED SERVICES UNDER THIS SECTION IN CONJUNCTION WITH PROGRAMS THAT HAVE LIMITED POOLS OF PROVIDERS OR WITH MANAGED CARE ARRANGEMENTS, AS IMPLEMENTED THROUGH 53-6-116 AND AS AUTHORIZED UNDER SECTION 1915 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396N, OR IN CONJUNCTION WITH A HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION INITIATIVE OR OTHER DEMONSTRATION PROJECT AS AUTHORIZED UNDER SECTION 1115 OF TITLE XI OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1315. <A]

[D> (2) <D] [A> (10) (A) <A] The department may conduct long-term care preadmission screenings [D> and resident reviews <D] [A> IN ACCORDANCE WITH SECTION 1919 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396R <A] .

[A> (B) <A] Long-term care preadmission screenings [D> and resident reviews <D] are required for all [D> medicaid-eligible <D] persons [D> entering <D] [A> SEEKING ADMISSION TO A <A] long-term care [D> facilities and community-based services and for all persons who become eligible for medicaid after entering long-term care facilities, before payment for services in such settings are authorized under medicaid. Preadmission screenings and resident review of

persons not applying for medical assistance under this part must be on a voluntary basis, except as required under the Social Security Act <D] [A> FACILITY <A] .

[A> (C) A PERSON DETERMINED THROUGH A LONG-TERM CARE PREADMISSION SCREENING TO HAVE MENTAL RETARDATION OR A MENTAL ILLNESS MAY NOT RESIDE IN A LONG-TERM CARE FACILITY UNLESS THE PERSON MEETS THE LONG-TERM CARE LEVEL-OF-CARE DETERMINATION APPLICABLE TO THE TYPE OF FACILITY AND IS DETERMINED TO HAVE A PRIMARY NEED FOR THE CARE PROVIDED THROUGH THE FACILITY. <A]

[A> (D) THE LONG-TERM CARE PREADMISSION SCREENINGS MUST INCLUDE A DETERMINATION OF WHETHER THE PERSON NEEDS SPECIALIZED MENTAL RETARDATION OR MENTAL HEALTH TREATMENT WHILE RESIDING IN THE FACILITY. <A]

[D> (3) The department shall annually advise medical doctors and current residents of long-term care facilities of the program provided in subsection (1). <D]

[D> (4) <D] [A> (11) <A] The department may adopt rules necessary to implement [D> a program of community-based medicaid services and to establish a system of <D] [A> THE <A] long-term care preadmission [D> screenings and resident reviews as part of that program <D] [A> SCREENING PROCESS AS REQUIRED BY SECTION 1919 OF TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396R. THE RULES MUST PROVIDE CRITERIA, PROCEDURES, SCHEDULES, DELEGATIONS OF RESPONSIBILITIES, AND OTHER REQUIREMENTS NECESSARY TO IMPLEMENT LONG-TERM CARE PREADMISSION SCREENINGS <A] .

[A> (12) THE DEPARTMENT SHALL ADOPT RULES NECESSARY FOR THE IMPLEMENTATION OF EACH PROGRAM OF HOME AND COMMUNITY-BASED SERVICES. THE RULES MAY INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: <A]

[A> (A) THE POPULATIONS OR SUBSETS OF POPULATIONS, AS PROVIDED IN SUBSECTION (6), TO BE SERVED IN EACH PROGRAM; <A]

[A> (B) LIMITS ON ENROLLMENT; <A]

[A> (C) LIMITS ON PER CAPITA EXPENDITURES; <A]

[A> (D) REQUIREMENTS AND LIMITATIONS FOR SERVICE COSTS AND EXPENDITURES; <A]

[A> (E) ELIGIBILITY CATEGORIES CRITERIA, REQUIREMENTS, AND RELATED MEASURES; <A]

[A> (F) DESIGNATION AND DESCRIPTION OF THE TYPES AND FEATURES OF THE PARTICULAR SERVICES PROVIDED FOR UNDER SUBSECTION (8); <A]

[A> (G) PROVIDER REQUIREMENTS AND REIMBURSEMENT; <A]

[A> (H) FINANCIAL PARTICIPATION REQUIREMENTS FOR ENROLLEES AS PROVIDED IN SUBSECTION (5); <A]

[A> (I) UTILIZATION MEASURES; <A]

[A> (J) MEASURES TO ENSURE THE APPROPRIATENESS AND QUALITY OF SERVICES TO BE DELIVERED; AND <A]

[A> (K) OTHER APPROPRIATE PROVISIONS NECESSARY TO THE ADMINISTRATION OF THE PROGRAM AND THE DELIVERY OF SERVICES IN ACCORDANCE WITH 42 U.S.C. 1396N AND ANY CONDITIONS PLACED UPON APPROVAL OF A PROGRAM BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. <A] "

Section 4. Directions to code commissioner. Wherever a reference to "community-based medicaid services" appears in legislation enacted by the 2005 legislature, the code commissioner is directed to change it to an appropriate reference to "home and community-based services".

Section 5. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 6. Effective date. [This act] is effective on passage and approval.

SPONSOR: Keenan

OLMSTEAD INITIATIVES

THE STATE OF COLORADO

COLORADO 1ST REGULAR SESSION OF THE 65TH GENERAL ASSEMBLY

HOUSE BILL 1243

AN ACT
HOUSE BILL 05-1243
BY REPRESENTATIVE(S) JAHN, BERENS, BOYD, CARROLL T., COLEMAN, FRANGAS, GARCIA,
GREEN, MADDEN, MCCLUSKEY, MERRIFIELD, SOLANO, STAFFORD, AND TODD;
ALSO SENATOR(S) JOHNSON, EVANS, FITZ-GERALD, GROFF, HAGEDORN, HANNA, ISGAR,
JONES, KELLER, KESTER, LAMBORN, MITCHELL, SANDOVAL, SHAFFER, SPENCE, TAPIA,
TAYLOR, TECK, TOCHTROP, TUPA, VEIGA, WIENS, WILLIAMS, AND WINDELS.

VERSION: Enacted

VERSION-DATE: June 3, 2005

SYNOPSIS: CONCERNING CONSUMER-DIRECTED CARE UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", AND MAKING AN APPROPRIATION THEREFOR.

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]
[D> Text within these symbols is deleted <D]

TEXT: Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 26-4-1301, Colorado Revised Statutes, is amended to read:

26-4-1301. Definitions. As used in this part 13, unless the context otherwise requires:

(1) [A> "ATTENDANT SUPPORT" MEANS ANY ACTION TO ASSIST AN ELIGIBLE PERSON IN ACCOMPLISHING ACTIVITIES OF DAILY LIVING, INSTRUMENTAL ACTIVITIES OF DAILY LIVING, AND HABILITATIVE AND HEALTH-RELATED TASKS. SUCH ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, PERSONAL CARE SERVICES, HOUSEHOLD SERVICES, COGNITIVE SERVICES, MOBILITY SERVICES, AND HEALTH-RELATED TASKS. <A]

[D> (1) <D] [A> (1.5) <A] "Authorized representative" means an individual designated by the eligible person, [A> BY THE PARENT OF A MINOR, <A] or by the [A> LEGAL <A] guardian of the eligible person [D> if appropriate <D] [A> IF THE ELIGIBLE PERSON CANNOT DEMONSTRATE SOUND JUDGMENT TO HIS OR HER PRIMARY CARE PHYSICIAN, <A] who has the judgment and ability to assist the eligible person in acquiring and utilizing services under this part 13. The extent of the authorized representative's involvement shall be determined upon designation.

(2) "Consumer-directed" means [D> that an eligible person receives a direct payment through a voucher to purchase qualified services. The direct payment received by the eligible person to pay for qualified services shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility <D] [A> THAT AN ELIGIBLE PERSON RECEIVES A DIRECT PAYMENT THROUGH A VOUCHER AND EMPLOYS, TRAINS, AND IN OTHER WAYS MANAGES THE PERSON WHO PROVIDES HIS OR HER ATTENDANT SUPPORT. THE DIRECT PAYMENT THROUGH A VOUCHER THAT IS RECEIVED BY AN ELIGIBLE PERSON TO PAY FOR ATTENDANT SUPPORT SHALL NOT BE COUNTED AS INCOME FOR PURPOSES OF DETERMINING ELIGIBILITY FOR MEDICAID AND OTHER STATE PROGRAMS THAT USE INCOME TO DETERMINE ELIGIBILITY. <A]

(3) "Eligible person" means [D> an elderly <D] [A> A <A] person who is eligible to receive services under [D> subpart 1 of <D] part 6 of article 4 of this title [A> OR ANY OTHER HOME- AND COMMUNITY- BASED SERVICE WAIVER FOR WHICH THE STATE DEPARTMENT HAS FEDERAL WAIVER AUTHORITY. <A]

(3.5) [A> "PRIMARY CARE PHYSICIAN" MEANS A PHYSICIAN WHO IS THE PRIMARY PROVIDER OF PHYSICIAN SERVICES TO THE ELIGIBLE PERSON OR WHO IS FAMILIAR WITH THE ELIGIBLE PERSON'S NEEDS AND CAPABILITIES. <A]

(4) "Qualified services" means [D> home- and community-based services as specified in section 26-4-607 (1) <D] [A> SERVICES PROVIDED UNDER THE ELIGIBLE PERSON'S APPLICABLE WAIVER PROGRAM AND ATTENDANT SUPPORT. <A]

SECTION 2. 26-4-1302, Colorado Revised Statutes, is amended to read:

26-4-1302. Service model - consumer-directed care. (1) The state department shall implement a consumer-directed care [D> program <D] [A> SERVICE MODEL <A] that allows eligible persons to receive a direct payment through a voucher to purchase qualified services. The state department is authorized to seek any federal waivers or waiver amendments that may be necessary to implement this part 13. The state department shall design and implement the [D> program <D] [A> CONSUMER-DIRECTED CARE SERVICE MODEL <A] with input from [D> elderly <D] consumers of home- and community-based services or their authorized representatives. [A> AN ELIGIBLE PERSON SHALL NOT BE REQUIRED TO DISENROLL FROM THE PERSON'S WAIVER PROGRAM IN ORDER TO RECEIVE QUALIFIED SERVICES THROUGH THE CONSUMER-DIRECTED CARE SERVICE MODEL. <A]

(2) In order to qualify and to remain eligible for the [D> program <D] [A> CONSUMER-DIRECTED CARE SERVICE MODEL <A] authorized by this section, [D> an elderly <D] [A> A <A] person shall:

(a) Be eligible for home- and community-based services under [D> subpart 1 of <D] part 6 of article 4 of this title [A> OR ANY OTHER HOME- AND COMMUNITY-BASED SERVICE WAIVER FOR WHICH THE STATE DEPARTMENT HAS FEDERAL WAIVER AUTHORITY; <A]

(b) Be willing to participate [A> ; <A] [D> in the program; <D]

(c) Obtain a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care or has an authorized representative;

(d) Demonstrate the ability to handle the financial aspects of self-directed care or has an authorized representative who is able to handle the financial aspects of the eligible person's care; [A> AND <A]

(e) Meet any other qualifications established by the medical services board by rule.

(3) The voucher issued to the eligible person under this [D> program <D] [A> PART 13 <A] shall be based on the eligible person's historical utilization of home- and community-based services under [D> subpart 1 of <D] part 6 of this article, [D> or, <D] the single entry point agency's care plan, or [A> ANY APPROVED RESOURCE ALLOCATION PROCESS AS DETERMINED BY THE STATE DEPARTMENT AND THE DEPARTMENT OF HUMAN SERVICES <A] for the eligible person.

(4) While an eligible person is participating in the consumer-directed care [D> program <D] [A> SERVICE MODEL <A] established in this part 13, that person shall be ineligible to receive a home care allowance as provided in section 26-2-122.3 (1) (b).

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of eligible persons under this part 13.

(6) The medical services board shall adopt rules as necessary for the implementation and administration of the [D> program <D] [A> CONSUMER-DIRECTED CARE SERVICE MODEL <A] authorized by this part 13. Such rules shall include a provision allowing an eligible person to designate a family member or authorized representative to be responsible for managing the financial matters associated with the consumer-directed care or to direct the eligible person's care. [D> Except as provided in section 26-4-609, such <D] [A> THE <A] designee shall not receive reimbursement for [D> his or her services <D] [A> MANAGING THE FINANCIAL MATTERS ASSOCIATED WITH THE ELIGIBLE PERSON'S CARE OR FOR DIRECTING THE ELIGIBLE PERSON'S CARE. <A]

(7) [A> SECTIONS 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (A), 12-38.1-102 (5), AND 12-38.1-117 (1) (B), C.R.S., SHALL NOT APPLY TO A PERSON WHO IS DIRECTLY EMPLOYED BY AN INDIVIDUAL PARTICIPATING IN THE CONSUMER-DIRECTED CARE SERVICE MODEL PURSUANT TO THIS SECTION AND WHO IS ACTING WITHIN THE SCOPE AND COURSE OF SUCH EMPLOYMENT. HOWEVER, SUCH PERSON MAY NOT REPRESENT HIMSELF OR HERSELF TO THE PUBLIC AS A LICENSED NURSE, A CERTIFIED NURSE AIDE, A LICENSED PRACTICAL OR PROFESSIONAL NURSE, A REGISTERED NURSE, OR A REGISTERED PROFESSIONAL NURSE. THIS EXCLUSION SHALL NOT APPLY TO ANY PERSON WHO HAS HAD HIS OR HER LICENSE AS A NURSE OR CERTIFICATION AS A NURSE AIDE SUSPENDED OR REVOKED OR HIS OR HER APPLICATION FOR SUCH LICENSE OR CERTIFICATION DENIED. <A]

(8) [A> SECTION 26-4-609 DOES NOT APPLY TO A FAMILY MEMBER OF AN ELIGIBLE PERSON WHO PROVIDES CONSUMER-DIRECTED CARE SERVICES TO THE ELIGIBLE PERSON PURSUANT TO THIS PART 13. <A]

(9) [A> A PERSON WHO HAS BEEN DESIGNATED AS AN AUTHORIZED REPRESENTATIVE UNDER THIS PART 13 SHALL SUBMIT AN AFFIDAVIT, WHICH SHALL BECOME PART OF THE ELIGIBLE PERSON'S FILE, STATING THAT: <A]

(a) [A> HE OR SHE IS AT LEAST EIGHTEEN YEARS OF AGE; <A]

(b) [A> HE OR SHE HAS KNOWN THE ELIGIBLE PERSON FOR AT LEAST TWO YEARS; <A]

(c) [A> HE OR SHE HAS NOT BEEN CONVICTED OF ANY CRIME INVOLVING EXPLOITATION, ABUSE, OR ASSAULT ON ANOTHER PERSON; AND <A]

(d) [A> HE OR SHE DOES NOT HAVE A MENTAL, EMOTIONAL, OR PHYSICAL CONDITION THAT COULD RESULT IN HARM TO THE ELIGIBLE PERSON. <A]

SECTION 3. 26-4-607 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-607. Services for the elderly, blind, and disabled. (1) Subject to the provisions of this subpart 1, home- and community-based services for the elderly, blind, and disabled shall include only the following services:

(k) [A> SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE SERVICE MODEL, PART 13 OF THIS ARTICLE. <A]

SECTION 4. 26-4-623 (4) (b), Colorado Revised Statutes, is amended to read:

26-4-623. Definitions. As used in this subpart 2, unless the context otherwise requires:

(4) (b) "Services for the developmentally disabled" includes, but is not limited to: Social, habilitative, remedial, residential, [D> and <D] health services, [A> AND SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE SERVICE MODEL, PART 13 OF THIS ARTICLE, WHICH SHALL INCLUDE THE SELECTION, FROM A LIST OF QUALIFIED ENTITIES, OF AN ORGANIZATION OF THE ELIGIBLE PERSON'S CHOICE TO PROVIDE FINANCIAL MANAGEMENT SERVICES FOR THE ELIGIBLE PERSON. <A]

SECTION 5. 26-4-645 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-645. Services for long-term-care eligible persons. (1) Subject to the provisions of this subpart 3, the home- and community-based services program for persons with HIV/AIDS shall include the following continuum of long-term care services:

(j) [A> SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE MODEL, PART 13 OF THIS ARTICLE. <A]

SECTION 6. 26-4-675 (1), Colorado Revised Statutes, is amended to read:

26-4-675. Implementation of program for mentally ill authorized - federal waiver - duties of the department of health care policy and financing and the department of human services. (1) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with major mental illnesses. The program shall be designed to provide home- and community-based services to eligible persons. Eligibility may be limited to persons who meet the level of services provided in a nursing facility, and services for eligible persons may be

established in medical services board rules to the extent such eligibility criteria and services are authorized or required by federal waiver. [A> THE PROGRAM SHALL INCLUDE SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE SERVICE MODEL, PART 13 OF THIS ARTICLE. <A]

SECTION 7. 26-4-684 (2), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-684. Implementation of home- and community-based services program for persons with brain injury authorized - federal waiver - duties of the department. (2) Services for eligible persons may be established in department rules to the extent authorized or required by federal waiver, but shall include at least the following:

(k) [A> SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE SERVICE MODEL, PART 13 OF THIS ARTICLE. <A]

SECTION 8. 26-4-694 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-694. Services - duties of the state department - rules. (1) Subject to the provisions of this subpart 7, home- and community-based services for children with autism shall include only the following services, as specified in the eligible child's care plan:

(f) [A> SERVICES PROVIDED UNDER THE CONSUMER-DIRECTED CARE SERVICE MODEL, PART 13 OF THIS ARTICLE. <A]

SECTION 9. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-113. Federal authorization - repeal. (1) [A> AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES: <A]

(a) [A> "ELIGIBLE PERSON" MEANS A PERSON WHO IS ELIGIBLE TO RECEIVE SERVICES UNDER PART 6 OF ARTICLE 4 OF TITLE 26, C.R.S., OR ANY OTHER HOME- AND COMMUNITY-BASED SERVICE WAIVER FOR WHICH THE STATE DEPARTMENT HAS FEDERAL WAIVER AUTHORITY. <A]

(b) [A> "QUALIFIED SERVICES" MEANS SERVICES PROVIDED UNDER THE ELIGIBLE PERSON'S APPLICABLE WAIVER PROGRAM AND ATTENDANT SUPPORT. <A]

(2) [A> THE STATE DEPARTMENT SHALL AMEND THE NECESSARY WAIVERS TO ALLOW AN ELIGIBLE PERSON TO RECEIVE QUALIFIED SERVICES THROUGH THE CONSUMER-DIRECTED CARE SERVICE MODEL. <A]

(3) [A> THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2007. <A]

SECTION 10. 26-4-902, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

26-4-902. Definitions. As used in this part 9, unless the context otherwise requires:

(1.5) [A> "AUTHORIZED REPRESENTATIVE" MEANS AN INDIVIDUAL DESIGNATED BY THE CONSUMER OF ATTENDANT SUPPORT, THE PARENT OF A MINOR, OR THE LEGAL GUARDIAN OF THE CONSUMER OF ATTENDANT SUPPORT, IF APPROPRIATE, WHO HAS THE JUDGMENT AND ABILITY TO ASSIST THE CONSUMER OF ATTENDANT SUPPORT IN ACQUIRING AND UTILIZING SERVICES UNDER THIS PART 9. THE EXTENT OF THE AUTHORIZED REPRESENTATIVE'S INVOLVEMENT SHALL BE DETERMINED UPON DESIGNATION. THE AUTHORIZED REPRESENTATIVE SHALL NOT BE THE CONSUMER'S SERVICE PROVIDER. <A]

(4) [A> "PRIMARY CARE PHYSICIAN" MEANS A PHYSICIAN WHO IS THE PRIMARY PROVIDER OF PHYSICIAN SERVICES TO THE PERSON WITH A DISABILITY OR WHO IS FAMILIAR WITH THE PERSON'S NEEDS AND CAPABILITIES. <A]

SECTION 11. 26-4-903 (2) (b) and (5), Colorado Revised Statutes, are amended, and the said 26-4-903 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-4-903. Pilot program - consumer-directed attendant support. (2) (b) In order to qualify and to remain eligible for the pilot program authorized by this section, a person with a disability shall:

(I) Be willing to participate in the pilot program;

(II) Be eligible for medicaid. This pilot program may include persons whose gross income does not exceed three hundred percent of the current federal supplement security income benefit level and who are eligible for a home- and community-based program but who choose the pilot program authorized in subsection (1) of this section in lieu of a home- and community-based program.

(III) Demonstrate a current need for attendant support, [D> and have received medicaid-funded attendant support for the past twelve months, <D] as defined in rule by the state board;

(IV) Have a utilization review that indicates a predictable need for attendant support and a pattern of stable health, such as a person with a disability who seeks appropriate treatment for illnesses and conditions;

(V) Obtain a statement from his or her primary care physician that indicates such person with a disability has sound judgment, [A> OR THAT SUCH PERSON WITH A DISABILITY HAS AN AUTHORIZED REPRESENTATIVE, <A] and is in stable condition;

(VI) Demonstrate the ability to handle the financial aspects of self-directed attendant care [A> OR HAVE AN AUTHORIZED REPRESENTATIVE WHO IS ABLE TO HANDLE THE FINANCIAL ASPECTS OF SELF-DIRECTED ATTENDANT CARE; <A]

(VII) Demonstrate the ability to manage the health aspects of his or her life [A> OR HAVE AN AUTHORIZED REPRESENTATIVE TO MANAGE THE HEALTH ASPECTS OF THE ELIGIBLE PERSON; <A] and

(VIII) Demonstrate the ability to supervise attendants and to give clear directions [A> OR HAVE AN AUTHORIZED REPRESENTATIVE TO SUPERVISE ATTENDANTS AND TO GIVE CLEAR DIRECTIONS. <A]

(5) The state department [D> and the department of human services <D] shall adopt rules as

necessary for the implementation and administration of the pilot program authorized by this section. Such rules may include a provision allowing a person with a cognitive disability, such as a person with a developmental disability or person with a mental illness, to designate a family member or friend to be responsible for managing the financial matters associated with the self-directed attendant care. Such designee shall not [D> direct the attendant care or <D] receive reimbursement for his or her services.

(9) [A> A PERSON WHO HAS BEEN DESIGNATED AS AN AUTHORIZED REPRESENTATIVE UNDER THIS PART 9 SHALL SUBMIT AN AFFIDAVIT, WHICH SHALL BECOME PART OF THE FILE OF THE PERSON WITH A DISABILITY, STATING THAT: <A]

(a) [A> HE OR SHE IS AT LEAST EIGHTEEN YEARS OF AGE; <A]

(b) [A> HE OR SHE HAS KNOWN THE PERSON WITH A DISABILITY FOR AT LEAST TWO YEARS; <A]

(c) [A> HE OR SHE HAS NOT BEEN CONVICTED OF ANY CRIME INVOLVING EXPLOITATION, ABUSE, OR ASSAULT ON ANOTHER PERSON; AND <A]

(d) [A> HE OR SHE DOES NOT HAVE A MENTAL, EMOTIONAL, OR PHYSICAL CONDITION THAT COULD RESULT IN HARM TO THE PERSON WITH A DISABILITY. <A]

SECTION 12. Appropriation - adjustment in 2005 long bill. (1) For the implementation of this act, appropriations made in the annual general appropriation act to the department of health care policy and financing for the fiscal year beginning July 1, 2005, shall be adjusted as follows:

(a) The appropriation for the executive director's office, personal services is increased by twenty-six thousand five hundred seventy dollars ($ 26,570) and 0.5 FTE. Of said sum, thirteen thousand two hundred eighty-five dollars ($ 13,285) shall be from the general fund and thirteen thousand two hundred eighty-five dollars ($ 13,285) shall be from federal funds.

(b) The appropriation for the executive director's office, operating expenses is increased by three thousand seven hundred sixty-two dollars ($ 3,762). Of said sum, one thousand eight hundred eighty-one dollars ($ 1,881) shall be from the general fund and one thousand eight hundred eighty-one dollars ($ 1,881) shall be from federal funds.

(c) The appropriation for the executive director's office, medicaid management information system contract is increased by one hundred seventy thousand six hundred eight-eight dollars ($ 170,688). Of said sum, forty-two thousand six hundred seventy-two dollars ($ 42,672) shall be from the general fund and one hundred twenty-eight thousand sixteen dollars ($ 128,016) shall be from federal funds.

(d) The appropriation for the medical services premiums is increased by one million eight thousand three hundred seventy-five dollars ($ 1,008,375). Of said sum, five hundred four thousand one hundred eighty-eight dollars ($ 504,188) shall be from the general fund and five hundred four thousand one hundred eighty-seven dollars ($ 504,187) shall be from federal funds.

(e) The appropriation for the medical services premiums is decreased by two million twelve thousand seven hundred ninety dollars ($ 2,012,790). Of said sum, one million six thousand three hundred ninety-five dollars ($ 1,006,395) shall be from the general fund and one million six

thousand three hundred ninety-five dollars ($ 1,006,395) shall be from federal funds.

SECTION 13. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

SPONSOR: Jahn

THE STATE OF OKLAHOMA

OKLAHOMA FIRST SESSION OF THE 50TH LEGISLATIVE SESSION

SENATE BILL 1015

STATE OF OKLAHOMA
1ST SESSION OF THE 50TH LEGISLATURE (2005)
COMMITTEE SUBSTITUTE FOR ENGROSSED
SENATE BILL NO. 1015
BY: CAIN OF THE SENATE
AND
STEELE, LINDLEY AND MASS OF THE HOUSE

VERSION: Enacted

VERSION-DATE: June 6, 2005

SYNOPSIS: An Act relating to poor persons; creating the Oklahoma Self-Directed Care Act; providing short title; stating legislative findings and intent; defining terms; directing the Oklahoma Health Care Authority and the Department of Human Services to establish certain pilot program; providing for program implementation upon federal approval; requiring interagency cooperative agreements; allowing choice of provider and direction of service delivery; providing for participation of specified persons; providing program parameters and consumer responsibility; specifying roles and responsibilities of agencies and the fiscal intermediary; providing for certain reimbursement; specifying employment criteria for specified purposes; providing for promulgation of rules and necessary waiver applications; providing for compliance with federal regulations; stating legislative intent regarding certain funds; allowing development of certain feature; specifying minimum requirements; specifying conditions for and requiring expansion of pilot program for additional populations; requiring specified feasibility study; requiring certain actions prior to certain allocation; requiring program review by agencies; providing for appointment of certain committee for specified purpose; requiring modification of State Medic aid Personal Care Program for specified purpose; specifying public policy; creating the Strategic Planning Committee on the Olmstead Decision; providing for operation, membership, quorum, cochairs, proceedings, subcommittees and staffing of the Committee; requiring cooperation; providing for travel reimbursement; providing for duties and responsibilities of Committee; requiring a report of findings and recommendations; providing for codification; providing an effective date; and declaring an emergency.

TEXT: BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.12 of Title 56, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Self-Directed Care Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.13 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Legislature finds that it recognizes the need to nurture the autonomy of citizens of this state who have disabilities by providing home- and community-based care services in the least restrictive and most appropriate setting possible. The Legislature hereby intends to provide such individuals with more choices in and greater control over the purchase of the home- and community-based care services they receive.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.14 of Title 56, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Self-Directed Care Act:

1. "Ancillary services" means services in addition to basic services provided to a consumer and includes the following:

a. housekeeping chores which are incidental to the basic services furnished, or which are essential to the health and welfare of the consumer, and

b. transportation services to enable the consumer to gain access to waiver services and other community services, activities and resources;

2. "Basic services" shall include, but not be limited to:

a. getting in and out of bed, wheelchair or motor vehicle,

b. assistance with routine bodily functions including bathing and personal hygiene, dressing and grooming, and eating,

c. assistance in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in a home- and community-based setting,

d. respite services for non-paid caregivers, which may include services consisting of general household activities such as meal preparation and routine household care, and

e. health maintenance activities including, but not limited to, administration of medications by oral, rectal, vaginal, otic, ophthalmic, nasal, skin, topical, transdermal and gastrostomy tube routes, feedings through a tube, surface care of stoma sites, irrigation of catheter, and wound care if such activities in the opinion of the attending physician or licensed registered nurse may be performed safely in the home or community by a consumer-employed caregiver who has successfully completed competency-based training approved by the Department of Human Services;

3. "Budget allowance" means the amount of money made available each month to a consumer to purchase needed home- and community-based care services, based on the results of a functional needs assessment to be developed pursuant to the provisions of this act;

4. "Consumer" means a person who has chosen to participate in the program, has met the enrollment requirements, and has received an approved budget allowance;

5. "Fiscal intermediary" means an entity approved by the Oklahoma Health Care Authority that helps a consumer manage the budget allowance of the consumer, retains the funds, and processes employment information, processes tax information, processes workers'

compensation insurance premiums, reviews records to ensure correctness, writes paychecks to providers, and delivers paychecks to the consumer for distribution to providers and caregivers;

6. "Legal representative" means a person who is a legal guardian or conservator or who holds a durable power of attorney authorizing the making of health and medical care decisions as required by this section for a consumer;

7. "Personal care services" means those basic and ancillary services which enable the consumer in need of in-home care to live in the home and community of the consumer rather than in an institution and to carry out functions of daily living, self-care and mobility;

8. "Program" means the Self-Directed Care Pilot Program;

9. "Provider" means:

a. a person licensed to render services that are eligible for reimbursement under this program, for whom the consumer is not the employer of record, or

b. a consumer-employed caregiver for whom the consumer is the employer of record; and

10. "Representative" means an uncompensated individual designated by the consumer to assist in managing the budget allowance and needed services of the consumer.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.15 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. 1. The Oklahoma Health Care Authority and the Department of Human Services, hereinafter referred to as the Authority and the Department, respectively, are hereby directed to establish self-directed care pilot programs for the citizens of the state who have disabilities and are currently served by a home- and community-based waiver which shall be based on the principles of consumer choice and control.

2. The Department of Human Services shall implement each pilot program upon federal approval.

3. The Authority and the Department shall further establish interagency cooperative agreements to implement and administer each program.

4. Persons enrolled in the Self-Directed Care Pilot Program shall be authorized to choose the providers of services and to direct the delivery of services to best meet their long-term care needs.

5. The pilot program shall operate within funds appropriated by the Legislature.

B. Any person currently receiving waiver services in the home- and community-based waiver program as amended to include the Self-Directed Care Pilot Program and who is determined through the Department's assessment process to be able to direct his or her own care or to designate an eligible representative to assist the person in directing such care may choose to participate in the Self-Directed Care Pilot Program. For purposes of this section, a legal representative acts on behalf of the consumer.

C. 1. A consumer enrolled in the program shall be given a monthly budget allowance based on the results of his or her functional needs assessment.

2. The Department of Human Services shall develop purchasing guidelines, approved by the Authority, to assist a consumer in using the budget allowance to purchase needed, cost-effective services.

D A consumer shall use the budget allowance only to pay for home- and community-based services that meet the long-term needs of the consumer and are a cost-efficient use of funds including, but not limited to:

1. Ancillary services as defined in Section 3 of this act;

2. Basic services as defined in Section 3 of this act;

3. Homemaking and chores, including housework, meals, shopping and transportation;

4. Home modifications and assistive devices that may increase the consumer's independence or make it possible to avoid institutional placement;

5. Day care and respite care services provided by adult day care facilities;

6. Personal care and support services provided in an assisted living facility should such facilities be subsequently approved for reimbursement under the state Medicaid program;

7. Durable medical equipment and supplies; and

8. Adaptive equipment.

E. A consumer shall be allowed to choose providers of services, as well as when and how services will be provided. A qualified consumer-employed caregiver is a person who is not legally responsible for the consumer's care, who is eighteen (18) years of age or older, has passed a criminal background check and a registry check pursuant to Sections 1025.2 and 1025.3 of Title 56 of the Oklahoma Statutes, and has the training necessary to meet the needs of the consumer. When the consumer is the employer of record, the consumer's roles and responsibilities include, but are not limited to, the following:

1. Developing a job description;

2. Selecting caregivers and submitting information for a criminal history background check;

3. Establishing and communicating needs, preferences and expectations about services being purchased;

4. Providing payments and tax requirements;

5. Being considered employer of record for purposes of the Workers' Compensation Act and paying premiums for workers' compensation insurance from the budget allowance or being self-insured pursuant to the Workers' Compensation Act;

6. Directing and supervising consumer-employed caregivers;

7. Ensuring the accuracy and timely submission of records required by the fiscal intermediary; and

8. Terminating the employment of an unsatisfactory caregiver.

F. The roles and responsibilities of the Department include, but are not limited to:

1. Assessing the functional needs of each consumer to determine eligibility, developing a service plan, and establishing a budget allowance based on the needs assessment;

2 Offering or contracting for services which shall provide training, technical assistance, and support to the consumer;

3. Approving fiscal intermediaries;

4. Establishing minimum qualifications and training for all caregivers and providers;

5. Serving as the final arbiter of the fitness of any individual to be a caregiver or provider; and

6. Developing and implementing a quality assurance plan.

G. The responsibilities of the fiscal intermediary include, but are not limited to:

1. Providing recordkeeping services;

2. Retaining the monthly budget allowance;

3. Processing employment information;

4. Processing federal and state tax, unemployment and FICA;

5. Processing workers' compensation insurance premiums or payments for self-insurance pursuant to the Workers' Compensation Act;

6. Reviewing records to ensure correctness;

7. Writing paychecks to providers;

8. Completing criminal history background check and registry check for consumer-employed caregivers pursuant to Sections 1025.2 and 1025.3 of Title 56 of the Oklahoma Statutes; and

9. Delivering paychecks to the consumer for distribution to providers and caregivers.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.16 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. In order to implement the Oklahoma Self-Directed Care Act:

1. The Oklahoma Health Care Authority Board and the Commission for Human Services are hereby authorized to promulgate rules necessary to enact the provisions of this act;

2. The Oklahoma Health Care Authority shall take all actions necessary to ensure state compliance with federal regulations;

3. The Authority shall apply for any necessary federal waivers or waiver amendments required to implement the program;

4. The Legislature intends that, as consumers relocate from institutional settings to community-based options, funds used to serve consumers in institutional settings shall follow consumers to cover the cost of community-based services; and

5. The Department of Human Services or other applicable state entity for the population served may develop an electronic benefit transfer feature for the provision of self-directed care services to consumers.

B. The Oklahoma Self-Directed Care Act, at a minimum, shall meet the following requirements:

1. The cost in the aggregate of the services offered through the self-directed care plan shall be equal to or less than the cost of a home- and community-based waiver or comparable waiver program;

2. The baseline level of consumer satisfaction shall be measured by a third party prior to initiation of the Oklahoma Self-Directed Care Act;

3. The scope of services offered within the Self-Directed Care Pilot Program shall comply with current state statutes and rules, and federal regulations; and

4. Program evaluation which shall include an indication of whether consumer satisfaction for Self-Directed Care Pilot Program consumers is higher than or equal to consumer satisfaction for home- and community-based waiver clients or other comparable waiver programs, as measured by a third party.

C. Upon the approval of the Centers for Medicare and Medicaid Services and the availability of funds, the Authority and the Department shall expand the Oklahoma Self-Directed Care Pilot Program statewide if the evaluation provided for in subsection B of this section demonstrates consumer satisfaction with and cost-effectiveness in the delivery of the program.

D. The Authority and the Department shall conduct a feasibility study on the future design and implementation of expanding the home- and community-based waiver program to include additional people with developmental disabilities, spinal cord injury or traumatic brain injury; provided, however, before allocating any new monies to such program, the Department and the Authority shall prepare and submit to the Legislature the results of the feasibility study and a fiscal impact statement.

E. The Authority and the Department of Human Services shall each, on an ongoing basis, review and assess the implementation of the Self-Directed Care Pilot Program. By January 15 of each year, the Authority shall submit a written report to the Governor and Legislature that includes each agency's review of the program.

F. The Department of Human Services shall appoint a committee to assist the Department in the development of waivers and rules related to self-directed services, including the functional

needs assessment used for determination of eligibility for the Self-Directed Services program. The committee shall be composed of two consumers; two parents or family members of consumers; two advocates; one representative from the Statewide Independent Living Council; one representative of an agency providing Advantage waiver services; one representative of an agency providing Developmental Disabilities Services Division waiver services; and one representative from the University of Oklahoma Health Sciences Center for Learning and Leadership. The committee shall sunset no later than one (1) year after the effective date of this act. The Governor, President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each appoint an at-large representative to the Committee.

G. The Authority is hereby directed to modify the state Medicaid program Personal Care Program to allow any person to self-direct his or her own personal care services who:

1. Is eligible to receive Personal Care Program services;

2. Chooses to receive Personal Care Program services; and

3. Is able to direct his or her own care or to designate an eligible representative to assist in directing such care.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 198.11 b of Title 56, unless there is created a duplication in numbering, reads as follows:

A. It is the public policy of the State of Oklahoma to:

1. Recognize and support individuals with disabilities by treating them with dignity and respect as productive members of our society in Oklahoma;

2. Acknowledge their contributions as productive and independent citizens in the state and the useful work they perform in their local communities;

3. Support a service delivery system for individuals with disabilities ensuring that the individuals, their families, or guardians are well informed as to the types of services and resources available to such individuals in order to encourage their independence, self-esteem, and self-worth, regardless of the severity of the disability; and

4. Recognize that self-choice on the part of individuals with disabilities is critical and that the most appropriate setting for meeting their needs should be a paramount consideration when determining appropriate placement of such individuals in community-based programs, residential care facilities, or any other placement or service that benefits the needs and well-being of individuals with disabilities.

B. There is hereby created the Strategic Planning Committee on the Olmstead Decision to continue until January 1, 2007. The purpose of the Committee is to develop a comprehensive, strategic plan of implementation for the State of Oklahoma regarding the Olmstead Decision.

C. The Strategic Planning Committee on the Olmstead Decision shall be composed of seventeen appointed members, eighteen ex officio members, and representatives from disability-related organizations, all of whom shall be voting members, as follows:

1. a. The Governor shall appoint:

(1) one person who is a community placement service provider for persons with disabilities,

(2) one person who is an advocate for persons with disabilities,

(3) one parent or personal representative of a person with disabilities,

(4) one member from an organization that provides direct care services within the Advantage Waiver Program, and

(5) one member who is a consumer of disability services.

b. The President Pro Tempore of the Senate shall appoint:

(1) one member of the State Senate who is a member of the Human Resources Committee,

(2) one member of the State Senate who is a member of the Appropriations Subcommittee on Health and Human Services,

(3) a representative of a nonprofit agency, in a

city of five hundred thousand (500,000) or more population, that collaborates on programs and services for persons with disabilities,

(4) two members who are consumers of disability services, and

(5) one member of the State Senate.

c. The Speaker of the House of Representatives shall appoint:

(1) one member of the House of Representatives who is a member of the Human Services Committee,

(2) one member of the House of Representatives who is a member of the Mental Health Committee,

(3) one parent or personal representative of a person with disabilities,

(4) two members who are consumers of disability services, and

(5) one member of the Oklahoma House of Representatives;

2. The ex officio voting members shall be:

a. the Attorney General, or designee,

b. the Director of the Department of Human Services, or designee,

c. the Division Director of the Developmental Disabilities Division of the Department of Human Services, if not the designee of the Director of Human Services,

d. the State Commissioner of Health, or designee,

e. the Commissioner of the Department of Mental Health and Substance Abuse Services, or designee,

f. the Administrator of the Oklahoma Health Care Authority, or designee,

g. the Director of the Office of State Finance, or designee,

h. the Director of the State Department of Rehabilitation Services, or designee,

i. the Director of the Office of Handicapped Concerns, or designee,

j. the Director of the Oklahoma Employment Security Commission, or designee,

k. the state coordinator for the federal Ticket To Work and Work Incentive Act, if not the designee of the Oklahoma Employment Security Director,

l. the Executive Director of a local housing authority, or designee,

m. the Executive Director of the Oklahoma Housing Finance Agency, or designee,

n. the State Superintendent of Public Instruction, or designee,

o. the Director of the Department of Transportation, or designee,

p. the Commissioner of Labor, or designee,

q. a representative from a local transit authority, or from a Community Action Agency, that provides transportation services to individuals with disabilities, and

r. the Director of the Oklahoma Commission on Children and Youth, or designee; and

3. The membership may also include as voting members, but need not be limited to, a representative from each of the following disability-related organizations:

a. the Developmental Disabilities Council,

b. the Statewide Independent Living Council,

c. the Centers for Independent Living,

d. the Center for Learning and Leadership,

e. the Oklahoma Disability Law Center,

f. ABLE-Tech, and

g. the Oklahoma Mental Health Consumer Council.

D. 1. Members shall serve at the pleasure of their appointing authorities. A vacancy on the Committee shall be filled by the original appointing authority.

2. The Committee shall be composed of persons serving on the Strategic Planning Committee on the Olmsted Decision, immediately prior to enactment of Enrolled House Bill No. 1253 of the 1st Session of the 50th Oklahoma Legislature.

3. A majority of the members of the Committee shall constitute a quorum. A majority of the members present at a meeting may act for the Committee.

4. The President Pro Tempore and the Speaker shall each designate a cochair from among the members of the Committee.

5. The cochairs of the Committee shall annually establish a schedule of each year's meetings. The Committee shall meet at least four times annually.

6. Proceedings of all meetings of the Committee shall comply with the provisions of the Oklahoma Open Meeting Act.

7. The Committee may divide into subcommittees in furtherance of its purpose.

E. 1. The Department of Human Services and the Office of the Attorney General shall serve as lead agencies and as such shall provide primary staffing for the Committee. Appropriate personnel from the Oklahoma Health Care Authority and the Department of Mental Health and Substance Abuse Services shall also assist with the work of the Committee.

2. The Committee may use the expertise and services of the staffs of the State Senate and the House of Representatives and may, as necessary, employ and contract for the advice and services of experts in the field as well as other necessary professional and clerical staff.

F. All departments, officers, agencies, and employees of this state shall cooperate with the Committee in fulfilling its duties and responsibilities including, but not limited to, providing any information, records, or reports requested by the Committee.

G. Members of the Committee shall receive no compensation for their service, but shall receive travel reimbursement as follows:

1. Legislative members of the Committee shall be reimbursed for necessary travel expenses incurred in the performance of their duties in accordance with the provisions of Section 456 of Title 74 of the Oklahoma Statutes; and

2. Nonlegislative members of the Committee shall be reimbursed by their appointing authorities or respective agencies for necessary travel expenses incurred in the performance of their duties in accordance with the State Travel Reimbursement Act.

H. The duties and responsibilities of the Strategic Planning Committee on the Olmstead Decision shall include, but need not be limited to:

a. developing a comprehensive, strategic plan for Oklahomans with disabilities, pursuant to the Olmstead Decision,

b. reviewing Oklahoma's service delivery system and the way in which persons with disabilities currently access the services,

c. reviewing existing statutes, policies, programs, services and funding sources that affect Oklahomans with disabilities, including, but not limited to, identifying unique approaches and strategies to funding,

d. identifying and reviewing funding and resource information available to persons with disabilities and their families in this state,

e. identifying gaps and barriers in programs and services to individuals with disabilities and making any recommendations to enhance programs and the delivery system for persons with disabilities in Oklahoma, and

f. taking all other actions necessary to develop the comprehensive strategic plan.

I. The Committee shall prepare and submit a report of its findings and recommendations to the Legislature and Governor by July 15, 2005, and each July 15 thereafter, and shall submit a final report by January 1, 2007.

SECTION 7. This act shall become effective July 1, 2005.

SECTION 8. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

SPONSOR: Cain

THE STATE OF NEW MEXICO

NEW MEXICO 47TH LEGISLATURE - SECOND REGULAR SESSION

HOUSE BILL 353

LAWS 2006
CHAPTER 112
HOUSE BILL 353, AS AMENDED

VERSION: Enacted - Final

VERSION-DATE: March 8, 2006

SYNOPSIS:

AN ACT

RELATING TO DISABILITIES; ENACTING THE MONEY FOLLOWS THE PERSON IN NEW MEXICO ACT.

TEXT: BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE.--This act may be cited as the "Money Follows the Person in New Mexico Act".

Section 2. DEFINITION.--As used in the Money Follows the Person in New Mexico Act, "department" means the aging and long-term services department.

Section 3. COMMUNITY-BASED LIVING-- CHOICE OF OPTIONS.-- An elderly or disabled individual who is identified and assessed as eligible for community-based living shall be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. The individual's medical assistance funds shall be made available for the individual for the service option the individual selects, not to exceed the cost of the service. The department shall apply for federal approval as necessary, and upon federal approval, implement this section under existing or future federal legislation.

Section 4. INFORMATION.--The department shall identify and provide adequate information to a medicaid-eligible individual residing in a nursing home and, if appropriate, the individual's representative, of the opportunity for the individual to receive community-based services and support pursuant to the Money Follows the Person in New Mexico Act.

Section 5. QUALITY IMPROVEMENT.--The department shall develop and implement a quality improvement system of performance indicators and outcome measures to evaluate the level and effectiveness of participation of individuals who are eligible for community-based services and to ensure that the services and support that an individual receives pursuant to the Money Follows the Person in New Mexico Act are adequate.

SPONSOR: Sandoval

THE STATE OF NEW JERSEY

NEW JERSEY 212TH LEGISLATURE

ASSEMBLY BILL 2823

VERSION: Enacted - Pamphlet Law

VERSION-DATE: June 22, 2006

SYNOPSIS: AN ACT concerning long-term care for Medicaid recipients and supplementing Title 30 of the Revised Statutes.

DIGEST:

Approved June 21, 2006.

TEXT: BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.30:4D-17.23 Short title.

1. This act shall be known and may be cited as the "Independence, Dignity and Choice in Long-Term Care Act."

C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.

2. The Legislature finds and declares that:

a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;

b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;

c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;

d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;

e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued

by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in Olmstead v. L.C. and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;

f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health and Senior Services, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global long-term care budgeting process designed to provide the Department of Health and Senior Services with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;

g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;

h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and

i. The enactment of this bill will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.

3. As used in this act:

"Commissioner" means the Commissioner of Health and Senior Services.

"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.

"Home and community-based care" means Medicaid home and community-based long-term care options available in this State, including, but not limited to, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program,

Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner, in consultation with the Commissioner of Human Services, shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) the provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act,

pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and

(b) the use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and

(2) commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. no later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and

b. no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community based long-term care options available to Medicaid recipients; and annual percentage changes in both long-term care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;

b. Commence the following no later than January 1, 2008:

(1) implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;

(2) identify home and community based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;

(3) develop and implement with the Commissioner of Human Services a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and

(4) develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and

c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.

7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Health and Senior Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health and Senior Services, Human Services and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.

b. The advisory council shall:

(1) monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and

(2) develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.

c. The advisory council shall comprise 15 members as follows:

(1) the commissioner, the Commissioner of Human Services and the State Treasurer, or their designees, as ex officio members; and

(2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.

d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.

e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

C.30:4D-17.30 Waiver of federal requirements.

8. The Commissioner of Human Services, with the approval of the Commissioner of Health and Senior Services, shall apply to the federal Centers for Medicare and Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

C.30:4D-17.31 Tracking of expenditures.

9. The commissioner, in consultation with the Commissioner of Human Services, shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.

10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.

11. This act shall take effect immediately.

SPONSOR: Whelan

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Chapter 263
2006 -- S 2628 SUBSTITUTE A AS AMENDED
Enacted 07/03/06

A N A C T
RELATING TO MEDICAL ASSISTANCE - LONG-TERM CARE SERVICE AND FINANCE REFORM

Introduced By: Senators Perry, Goodwin, Paiva-Weed, Pichardo, and Connors
Date Introduced: February 09, 2006

It is enacted by the General Assembly as follows:

SECTION 1. Title 40 of the General Laws entitled "HUMAN SERVICES" is hereby amended by adding thereto the following chapter:

CHAPTER 8.9
MEDICAL ASSISTANCE - LONG-TERM CARE SERVICE AND FINANCE REFORM

40-8.9-1. Findings. -- (a) The number of Rhode Islanders in need of long-term care services continues to rise substantially, and the quality of life of these Rhode Islanders is determined by the capacity of the long-term care system to provide access to the full array of services and supports required to meet their health care needs and maintain their independence.

(b) It is in the interest of all Rhode Islanders to endorse and fund statewide efforts to build a fiscally sound, dynamic long-term care system that supports: consumer independence and choice; the delivery of high quality, coordinated services; the financial integrity of all participants-purchasers, payers, providers and consumers; and the responsible and efficient allocation of all available public and private resources.

(c) It is in the interest of all Rhode Islanders to assure that rates paid for community-based long-term care services are adequate to assure high quality as well as supportive of workforce recruitment and retention.

(d) It is in the interest of all Rhode Islanders to improve consumer's access information regarding community-based alternatives to institutional settings of care.

40-8.9-2. System reform goal. -- On or before July 1, 2007, the department of human services shall begin to implement a model system for integrated long-term care, that expands the capacity of the long-term care system as a whole to support consumer choice and independence; enables consumers to access coordinated services; assures quality outcomes through certification
standards, performance measures and incentives and rewards that promote service excellence and generates the information consumers need to make reasoned choices about their health care; and improves the system's overall stability by reinvesting the benefits that accrue from the more efficient utilization of services to enhance the capacity of each of its component parts. Attaining system-wide reform of the magnitude set forth herein will require significant changes in the organization, financing and delivery of services that must be implemented incrementally.

40-8.9-3. Least restrictive setting requirement. -- Beginning on July 1, 2006, the department of human services is directed and authorized to allocate existing Medicaid resources as needed to ensure that those in need of long-term care and support services receive them in the least restrictive setting appropriate to their needs and preferences. The department is hereby authorized to utilize screening criteria, to avoid unnecessary institutionalization of persons during the full eligibility determination process for Medicaid community based care.

40-8.9-4. Unified long-term care budget. – Beginning on July 1, 2007, a unified long-term care budget shall combine in a single line-item within the department of human services budget, annual department of human services Medicaid appropriations for nursing facility and community-based long-term care services (including adult day care, home health, and personal care in assisted living settings). Beginning on July 1, 2007, the total system savings attributable to the value of the reduction in nursing home days paid for by Medicaid shall be allocated for the express purpose of promoting and strengthening community-based alternatives.

40-8.9-5. Administration and regulations. -- As the single state agency designated to administer the Rhode Island Medicaid program, the department is hereby directed and authorized to develop and submit any requests for waivers, demonstration projects, grants and state plan amendments or regulations that may be considered necessary and appropriate to support the general purposes of this statute. Such requests shall be made in consultation with any affected departments and, to the extent feasible, any consumer group, advisory body, or other entity designated for such purposes.

40-8.9-6. Reporting. -- Annual reports shall be submitted by the department to the Joint Legislative Committee on Health Care Oversight as well as the finance committees of both the senate and the house of representatives and shall include estimates of the investments necessary to provide stability to the existing system and establish the infrastructure and programs required to achieve system-wide reform.

40-8.9-7. Rate reform. – By January 2008 the department of human services shall design and require to be submitted by all service providers cost reports for all community-based long-term services.

40-8.9-8. System screening. – By January 2008 the department of human services shall develop and implement a screening strategy for the purpose of identifying entrants to the publicly financed long-term care system prior to application for eligibility as well as defining their potential service needs.

SECTION 2. Section 40-8.5-1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

40-8.5-1. Categorically needy medical assistance coverage. -- (a) The department of human services is hereby authorized and directed to amend its Title XIX state plan to provide for categorically needy medical assistance coverage as permitted pursuant to Title XIX of the Social Security Act [42 U.S.C. section 1396 et seq.] as amended to individuals who are sixty-five (65) years or older or are disabled (as determined under section 1614(a)(3)) of the Social Security Act [42 U.S.C. section 1382c(a)(3)] as amended whose income does not exceed one hundred percent
(100%) of the federal poverty level (as revised annually) applicable to the individual's family size, and whose resources do not exceed four thousand dollars ($4,000) per individual, or six

thousand dollars ($6,000) per couple. The department shall provide medical assistance coverage to such elderly or disabled persons in the same amount, duration and scope as provided to other categorically needy persons under the state's Title XIX state plan.

(b) In order to ensure that individuals with disabilities, have access to quality and affordable health care, the department is authorized to plan and to implement a system of health care delivery through a voluntary (opt-out) managed care health system for such individuals.

"Managed care" is defined as a system that: integrates an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care.

(c) The department is authorized to obtain any approval and/or waivers from the United States Department of Health and Human Services, necessary to implement a voluntary (opt-out) managed health care delivery system to the extent approved by the United States Department of Health and Human Services.

(d) The department shall submit a report to the Permanent Joint Committee on Health Care Oversight no later than April 1, 2006 that proposes an implementation plan for this voluntary program, based on beginning enrollment not sooner than July 1, 2006. The report will describe projected program costs and savings, the outreach strategy to be employed to educate the potentially eligible populations, the enrollment plan, and an implementation schedule.

(e) To ensure the delivery of timely and appropriate services to persons who become automatically eligible for Medicaid by virtue of their eligibility for a Social Security Administration program, data on their special needs may be reported to the department of human services by the Social Security Administration. The department of human services is authorized to seek any and all data sharing agreements or other agreements with the Social Security Administration as may be necessary to receive timely and accurate diagnostic data and clinical assessments to be used exclusively for the purpose of service planning, and to be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

SECTION 3. This act shall take effect upon passage.

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LC01942/SUB A

PREVENTION

THE STATE OF ILLINOIS

ILLINOIS 94TH GENERAL ASSEMBLY

SENATE BILL 506

VERSION: Enacted

VERSION-DATE: July 14, 2005

SYNOPSIS: AN ACT concerning children.

TEXT: Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Shaken Baby Prevention Act.

Section 5. Definitions. In this Act:

"Department" means the Department of Public Health.

"Director" means the Director of Public Health.

"Parent" means a biological mother or father, foster-mother or father, adoptive mother or father, or step-mother or step-father.

"Primary caregiver" means any person who is not a parent, but who provides temporary care to an infant or child, including but not limited to, a babysitter, child care provider, extended family member, nanny, or custodian.

"Shaken baby" means the vigorous shaking of an infant or a young child that may result in bleeding inside the head and cause one or more of the following conditions: irreversible brain damage; blindness, retinal hemorrhage, or eye damage; cerebral palsy; hearing loss; spinal cord injury, including paralysis; seizures; learning disability; central nervous system injury; closed head injury**;** rib fracture; subdural hematoma; or death.

Section 10. Shaken Baby Prevention Program. Subject to appropriation, the Director shall establish a statewide Shaken Baby Prevention Program to educate parents and primary caregivers about the dangers of shaken baby and to provide alternative techniques to venting anger and frustration. The program shall allow for voluntary participation and use multimedia educational vehicles, such as a video recording, to target the parents and primary caregivers of babies from birth through 3 years of age. Parents of newborns may choose to sign a participation form and fill out an evaluation form to record their participation in the program after viewing the multimedia educational materials. The Director, or the Director's designee, shall develop companion written materials, a program participation form, and an evaluation form. The Director shall designate and enter into contracts with experts, health care providers, and other State agencies to design and implement the program in all hospitals and child care facilities.

Section 15. Local health departments. Local health departments shall assist the Director in implementing and administering the Shaken Baby Prevention Program in local hospitals and child care facilities. Local health departments' specific duties may include, but are not limited to,

distributing the multimedia program materials and assisting in the collection of the data on program participation and the program evaluation forms for the Department's annual report required under Section 30.

Section 20. Responsibilities of hospitals, health care providers, and child care providers.

(a) Every hospital, maternal or pediatric health care provider, and child care provider shall encourage parents and primary caregivers to participate in the voluntary Shaken Baby Prevention Program by:

(1) informing parents of all newborn children about the program;

(2) making available to parents the shaken baby awareness and prevention multimedia materials provided by the Department;

(3) making program participation forms developed by the Department available for signing by parents after viewing the multimedia materials; and

(4) keeping all program participation forms and evaluation forms on file.

(b) Hospitals shall report to the Department by no later than the first of November of each year: (i) the total number of births that occurred at the hospital that year; (ii) the total number of viewings of the shaken baby multimedia educational materials; and (iii) the total number of Shaken Baby Prevention Program participation forms signed at the hospital. All evaluation forms filled out during the year shall be forwarded to the Department with that data.

Section 25. Parent support service. The Department may establish and operate a voluntary support service for parents who struggle with infant crying. The support service may include, but need not be limited to, telephone consultation and referrals to appropriate professional assistance.

Section 30. Annual report. The Department shall make an annual report to the General Assembly of its findings and recommendations concerning the effectiveness, impact, and benefits derived from the Shaken Baby Prevention Program. The report shall contain evaluations of the program and recommendations for legislation deemed necessary and proper. The Department shall submit the report on or before the first day of January, beginning in 2007.

Section 99. Effective date. This Act takes effect January 1, 2006.

SPONSOR: Haine

THE STATE OF NEW YORK

NEW YORK 229TH ANNUAL LEGISLATIVE SESSION

SENATE BILL 7008

INTRODUCED BY SENS. SPANO, SALAND, BONACIC, DEFRANCISCO, FARLEY, FUSCHILLO,
JOHNSON, LARKIN, LEIBELL, MAZIARZ, MORAHAN, PADAVAN, RATH, TRUNZO, VOLKER, WRIGHT, YOUNG -- READ TWICE AND ORDERED PRINTED, AND WHEN PRINTED TO BE COMMITTED TO THE COMMITTEE ON CODES

VERSION: Enacted

VERSION-DATE: June 28, 2006

SYNOPSIS: AN ACT to amend the penal law and the public health law, in relation to enacting "Cynthia's law"

NOTICE: [A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]

TEXT: THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. This act shall be known and may be cited as "Cynthia's law".

Section 2. Paragraph (c) of subdivision 1 of section 70.02 of the penal law, as separately amended by chapters 764 and 765 of the laws of 2005, is amended to read as follows:

(c) Class D violent felony offenses: an attempt to commit any of the class C felonies set forth in paragraph (b); [A> RECKLESS ASSAULT OF A CHILD AS DEFINED IN SECTION 120.02, <A] assault in the second degree as defined in section 120.05, menacing a police officer or peace officer as defined in section 120.18, stalking in the first degree, as defined in subdivision one of section 120.60, sexual abuse in the first degree as defined in section 130.65, course of sexual conduct against a child in the second degree as defined in section 130.80, aggravated sexual abuse in the third degree as defined in section 130.66, criminal possession of a weapon in the third degree as defined in subdivision four, five, six, seven or eight of section 265.02, criminal sale of a firearm in the third degree as defined in section 265.11, intimidating a victim or witness in the second degree as defined in section 215.16, soliciting or providing support for an act of terrorism in the second degree as defined in section 490.10, and making a terroristic threat as defined in section 490.20, falsely reporting an incident in the first degree as defined in section 240.60, placing a false bomb or hazardous substance in the first degree as defined in section 240.62, placing a false bomb or hazardous substance in a sports stadium or arena, mass transportation facility or enclosed shopping mall as defined in section 240.63, and aggravated unpermitted use of indoor pyrotechnics in the first degree as defined in section 405.18.

Section 3. The penal law is amended by adding a new section 120.02 to read as follows:

[A> SECTION 120.02 RECKLESS ASSAULT OF A CHILD. <A]

[A> 1. A PERSON IS GUILTY OF RECKLESS ASSAULT OF A CHILD WHEN, BEING EIGHTEEN YEARS OF AGE OR MORE, SUCH PERSON RECKLESSLY CAUSES SERIOUS PHYSICAL INJURY TO THE BRAIN OF A CHILD LESS THAN FIVE YEARS OLD BY SHAKING THE CHILD, OR BY SLAMMING OR THROWING THE CHILD SO AS TO IMPACT THE CHILD'S HEAD ON A HARD SURFACE OR OBJECT. <A]

[A> 2. FOR PURPOSES OF SUBDIVISION ONE OF THIS SECTION, THE FOLLOWING SHALL CONSTITUTE "SERIOUS PHYSICAL INJURY": <A]

[A> A. "SERIOUS PHYSICAL INJURY" AS DEFINED IN SUBDIVISION TEN OF SECTION 10.00 OF THIS CHAPTER; OR <A]

[A> B. EXTREME ROTATIONAL CRANIAL ACCELERATION AND DECELERATION AND ONE OR MORE OF THE FOLLOWING: (I) SUBDURAL HEMORRHAGING; (II) INTRACRANIAL HEMORRHAGING; OR (III) RETINAL HEMORRHAGING. <A]

[A> RECKLESS ASSAULT OF A CHILD IS A CLASS D FELONY. <A]

Section 4. The public health law is amended by adding a new section 2745 to read as follows:

[A> SECTION 2745. SHAKEN BABY SYNDROME PUBLIC EDUCATIONAL CAMPAIGN. THE DEPARTMENT SHALL DEVELOP AND IMPLEMENT AN ONGOING PUBLIC INFORMATION AND EDUCATIONAL CAMPAIGN TO INFORM THE GENERAL PUBLIC ABOUT BRAIN INJURIES AND OTHER HARMFUL EFFECTS THAT MAY RESULT FROM SHAKING INFANTS AND CHILDREN UNDER FIVE YEARS OF AGE. THE PROGRAM SHALL INCLUDE, WITHOUT LIMITATION, THE FOLLOWING ELEMENTS: EDUCATIONAL AND INFORMATIONAL MATERIALS IN PRINT, AUDIO, VIDEO, ELECTRONIC AND OTHER MEDIA AND PUBLIC SERVICE ANNOUNCEMENTS AND ADVERTISEMENTS. <A]

Section 5. This act shall take effect on the first of November next succeeding the date on which it shall have become a law.

SPONSOR: Spano

PUBLIC AWARENESS

THE STATE OF NEW JERSEY

NEW JERSEY 212TH LEGISLATURE

ASSEMBLY JOINT RESOLUTION 85

INTRODUCED JANUARY 30, 2006
SPONSORED BY:
ASSEMBLYMAN HERB CONAWAY, JR.

VERSION: Introduced

VERSION-DATE: January 30, 2006

SYNOPSIS

SYNOPSIS

Designates month of March in each year as **"**Brain Injury Awareness Month."

CURRENT VERSION OF TEXT

As introduced.

A Joint Resolution designating the month of March in each year as **"**Brain Injury Awareness Month."

WHEREAS, According to the federal Centers for Disease Control and Prevention (CDC), 1.5 million Americans sustain a traumatic brain injury (TBI) each year, and 500,000 of those individuals die as a result of these injuries; the CDC also indicates that approximately 5.3 million Americans live with disabilities resulting from brain injury, including 160,000 New Jersey residents; and

WHEREAS, With TBI occurring every 21 seconds, this public health concern ranks as the leading cause of death and disability in children and young adults; additionally, on an annual basis, 40,000 individuals over the age of 65 visit hospital emergency rooms for TBI as a result of a fall, leading to the hospitalization of 16,000 senior citizens and the death of 4,000 senior citizens; and

WHEREAS, The Department of Health and Senior Services states that each year, one-third of all injury deaths and 10% of injury hospitalizations in the State result from TBI, with the highest proportion occurring among young adults and the elderly; and

WHEREAS, The costs relating to brain injury are staggering, and individuals with severe brain injury typically face five to 10 years of intensive rehabilitation with cumulative costs exceeding $ 35 billion annually; and

WHEREAS, Individuals with severe brain injury suffer from serious physical impairments and a

variety of perceptual, cognitive, psychiatric, emotional and behavioral complications, including impaired interpersonal and problem-solving skills, memory loss, decreased thought-processing abilities, speech and seizure disorders, and physical deficits; and

WHEREAS, The only cure for TBI is prevention, and public awareness is critical to the prevention of brain injury and to enhancing the recovery process of all individuals affected by TBI; and

WHEREAS, The Brain Injury Association of New Jersey is a Statewide membership organization dedicated to providing education, outreach, prevention, advocacy and support services to all individuals affected by TBI and to the general public; now, therefore,

DIGEST:

STATEMENT

This joint resolution designates the month of March in each year as **"**Brain Injury Awareness Month" and requests the Governor to issue a proclamation calling upon public officials and the citizens of this State to observe the month with appropriate activities and programs.

TEXT: BE IT RESOLVED by the Senate and General Assembly of the State of New Jersey:

1. The month of March in each year is designated as "Brain Injury Awareness Month" in the State of New Jersey.

2. The Governor is hereby requested to issue a proclamation calling upon public officials and the citizens of this State to observe the month with appropriate activities and programs.

3. This joint resolution shall take effect immediately.

SPONSOR: Conaway

State Index