An act to amend Sections 1569.145, 1771, 1771.3, 1771.8, and 1790 of, and to add Section 1793.63 to, the Health and Safety Code, relating to residential care facilities for the elderly.

LEGISLATIVE COUNSEL’S DIGEST

AB 1022, as amended, Saldana. Continuing care home service.

Existing law provides for the regulation by the State Department of Social Services of activities relating to continuing care contracts that govern care provided to an elderly resident in a continuing care retirement community for the duration of the resident’s life or a term in excess of one year. Existing law designates the contents of a continuing care contract, including the conditions under which a resident of a continuing care retirement community may be voluntarily or involuntarily transferred from his or her designated living unit.

Under existing law, an entity that issues, delivers, or publishes, or as manager or officer or in any other administrative capacity, assists in the issuance, delivery, or publication of any printed matter, oral representation, or advertising material that does not comply with the
requirements of the law relating to continuing care contracts is guilty of a misdemeanor. This bill would exempt a care at-home program continuing care at home program, as defined, from the licensing provisions applicable to residential care facilities for the elderly, if certain conditions are met, and would set forth certain requirements for, and authorized services of, a continuing care at home program. The bill would increase from $7,500 to $10,000 the maximum entrance fee for certain residence agreements exempt from continuing care contract provisions, and would require annual adjustments for cost-of-living increases every four years. By revising the provisions relating to continuing care providers, this bill would change the definition of an existing crime, thus imposing a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason. Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1569.145 of the Health and Safety Code is amended to read:

1569.145. This chapter shall not apply to any of the following:
(a) Any health facility, as defined by Section 1250.
(b) Any clinic, as defined by Section 1202.
(c) Any facility conducted by and for the adherents of any well-recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.
(d) Any house, institution, hotel, congregate housing project for the elderly, or other similar place that is limited to providing one or more of the following: housing, meals, transportation, housekeeping, or recreational and social activities; or that have residents independently accessing supportive services; provided, however, that no resident thereof requires any element of care and supervision or protective supervision as determined by the director.
This subdivision shall not include a home or residence that is described in subdivision (f).

(e) Recovery houses or other similar facilities providing group living arrangements for persons recovering from alcoholism or drug addiction where the facility provides no care or supervision.

(f) (1) Any arrangement for the care and supervision of a person or persons by a family member.

(2) Any arrangement for the care and supervision of a person or persons from only one family by a close friend, whose friendship preexisted the contact between the provider and the recipient, and both of the following are met:

(A) The care and supervision is provided in a home or residence chosen by the recipient.

(B) The arrangement is not of a business nature and occurs only as long as the needs of the recipient for care and supervision are adequately met.

(g) Any housing for elderly or disabled persons, or both, that is approved and operated pursuant to Section 202 of Public Law 86-372 (12 U.S.C.A. Sec. 1701q), or Section 811 of Public Law 101-625 (42 U.S.C.A. Sec. 8013), or whose mortgage is insured pursuant to Section 236 of Public Law 90-448 (12 U.S.C.A. Sec. 1715z), or that receives mortgage assistance pursuant to Section 221d (3) of Public Law 87-70 (12 U.S.C.A. Sec. 17151), where supportive services are made available to residents at their option, as long as the project owner or operator does not contract for or provide the supportive services. The project owner or operator may coordinate, or help residents gain access to, the supportive services, either directly, or through a service coordinator.

(h) A care at-home program where a person or entity provides one or more services, including, but not limited to, meal preparation, housekeeping, laundry, home maintenance, grounds maintenance, companionship, social activities, recreational activities, and referrals to other care providers, to an elderly person in his or her private residence. A “care at-home program” includes a “continuing care at-home program,” as defined in paragraph (10) of subdivision (c) of Section 1771.

(i) Any similar facility determined by the director.
(j) For purposes of this section, “family member” means any spouse, by marriage or otherwise, child or stepchild, by natural birth or by adoption, parent, brother, sister, half brother, half sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, first cousin, or any person denoted by the prefix “grand” or “great,” or the spouse of any of these persons.

(2) “Private residence” means a house, apartment, or other dwelling where all of the following conditions are met:

(A) The elderly person is receiving services under a care at-home program occupies the dwelling.

(B) The dwelling is either owned or rented by the elderly person receiving services under a care at-home program or by a family member or close friend of this person.

(C) The dwelling is not licensed as a residential care facility for the elderly.

(D) A care at-home program services provider shall not have any interest in the dwelling, except when the care at-home program services provider also operates within the vicinity of the dwelling either a continuing care retirement community, as defined in paragraph (12) of subdivision (c) of Section 1771, or a multilevel retirement community that furnishes independent living accommodations, assisted living services, as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing services, in a manner that would qualify for a letter of exemption under Section 1771.3.

(k) A person shall not be exempted from this chapter’s licensure requirements if he or she has been appointed as conservator of the person, estate of the person, or both, if the person is receiving care and supervision from the conservator as regulated by this chapter, unless the conservator is otherwise exempted under other provisions of this section.

(k) An elderly person’s private residence where services are provided by a continuing care at home program as defined in paragraph (10) of subdivision (c) of Section 1771.

SEC. 2. Section 1771 of the Health and Safety Code is amended to read:
Unless the context otherwise requires, the definitions in this section govern the interpretation of this chapter.

(a) (1) “Affiliate” means any person, corporation, limited liability company, business trust, trust, partnership, unincorporated association, or other legal entity that directly or indirectly controls, is controlled by, or is under common control with, a provider or applicant.

(2) “Affinity group” means a grouping of entities sharing a common interest, philosophy, or connection (e.g., military officers, religion).

(3) “Annual report” means the report each provider is required to file annually with the department, as described in Section 1790.

(4) “Applicant” means any entity, or combination of entities, that submits and has pending an application to the department for a permit to accept deposits and a certificate of authority.

(5) “Assisted living services” includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychosocial comfort.

(6) “Assisted living unit” means the living area or unit within a continuing care retirement community that is specifically designed to provide ongoing assisted living services.

(7) “Audited financial statement” means financial statements prepared in accordance with generally accepted accounting principles including the opinion of an independent certified public accountant, and notes to the financial statements considered customary or necessary to provide full disclosure and complete information regarding the provider’s financial statements, financial condition, and operation.

(b) (reserved)

(c) (1) “Cancel” means to destroy the force and effect of an agreement or continuing care contract.

(2) “Cancellation period” means the 90-day period, beginning when the resident physically moves into the continuing care retirement community, during which the resident may cancel the continuing care contract, as provided in Section 1788.2.

(3) “Care” means nursing, medical, or other health-related services, protection or supervision, assistance with the personal activities of daily living, or any combination of those services.
(4) “Cash equivalent” means certificates of deposit and United States Treasury securities with a maturity of five years or less.
(5) “Certificate” or “certificate of authority” means the certificate issued by the department, properly executed and bearing the State Seal, authorizing a specified provider to enter into one or more continuing care contracts at a single specified continuing care retirement community.
(6) “Condition” means a restriction, specific action, or other requirement imposed by the department for the initial or continuing validity of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority. A condition may limit the circumstances under which the provider may enter into any new deposit agreement or contract, or may be imposed as a condition precedent to the issuance of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority.
(7) “Consideration” means some right, interest, profit, or benefit paid, transferred, promised, or provided by one party to another as an inducement to contract. Consideration includes some forbearance, detriment, loss, or responsibility, that is given, suffered, or undertaken by a party as an inducement to another party to contract.
(8) “Continuing care contract” means a contract that includes a continuing care promise made, in exchange for an entrance fee, the payment of periodic charges, or both types of payments. A continuing care contract may consist of one agreement or a series of agreements and other writings incorporated by reference.
(9) “Continuing care advisory committee” means an advisory panel appointed pursuant to Section 1777.
(10) “Continuing care at home program” means a program offered by a provider or a multilevel retirement community that meets the exemption from the continuing care contract provisions pursuant to subdivision (b) of Section 1771.3, that furnishes one or more services to an elderly person in the elderly person’s own private residence, including, but not limited to, meals, housekeeping, laundry, home maintenance, grounds maintenance, companionship, social activities, recreational activities, and referrals to other care providers. For the purposes of this paragraph, “private residence” does not include residence at a licensed continuing care retirement community facility or at a multilevel retirement community facility.
in subdivision (k) of Section 1569.145, operated by a continuing care provider, as defined in subdivision (p), that is authorized to enter into a continuing care contract pursuant to a currently valid certificate of authority or a provisional certificate of authority.

(11) “Continuing care promise” means a promise, expressed or implied, by a provider to provide one or more elements of care to an elderly resident for the duration of his or her life or for a term in excess of one year. Any such promise or representation, whether part of a continuing care contract, other agreement, or series of agreements, or contained in any advertisement, brochure, or other material, either written or oral, is a continuing care promise.

(12) “Continuing care retirement community” means a facility located within the State of California where services promised in a continuing care contract are provided. A distinct phase of development approved by the department may be considered to be the continuing care retirement community when a project is being developed in successive distinct phases over a period of time. When the services are provided in residents’ own homes, the homes into which the provider takes those services are considered part of the continuing care retirement community.

(13) “Control” means directing or causing the direction of the financial management or the policies of another entity, including an operator of a continuing care retirement community, whether by means of the controlling entity’s ownership interest, contract, or any other involvement. A parent entity or sole member of an entity controls a subsidiary entity provider for a continuing care retirement community if its officers, directors, or agents directly participate in the management of the subsidiary entity or in the initiation or approval of policies that affect the continuing care retirement community’s operations, including, but not limited to, approving budgets or the administrator for a continuing care retirement community.

(d) (1) “Department” means the State Department of Social Services.

(2) “Deposit” means any transfer of consideration, including a promise to transfer money or property, made by a depositor to any entity that promises or proposes to promise to provide continuing care, but is not authorized to enter into a continuing care contract with the potential depositor.
(3) “Deposit agreement” means any agreement made between
any entity accepting a deposit and a depositor. Deposit agreements
for deposits received by an applicant prior to the department’s
release of funds from the deposit escrow account shall be subject
to the requirements described in Section 1780.4.
(4) “Depository” means a bank or institution that is a member
of the Federal Deposit Insurance Corporation or a comparable
deposit insurance program.
(5) “Depositor” means any prospective resident who pays a
deposit. Where any portion of the consideration transferred to an
applicant as a deposit or to a provider as consideration for a
continuing care contract is transferred by a person other than the
prospective resident or a resident, that third-party transferor shall
have the same cancellation or refund rights as the prospective
resident or resident for whose benefit the consideration was
transferred.
(6) “Director” means the Director of Social Services.
(e) (1) “Elderly” means an individual who is 60 years of age
or older.
(2) “Entity” means an individual, partnership, corporation,
limited liability company, and any other form for doing business.
Entity includes a person, sole proprietorship, estate, trust,
association, and joint venture.
(3) “Entrance fee” means the sum of any initial, amortized, or
deferred transfer of consideration made or promised to be made
by, or on behalf of, a person entering into a continuing care contract
for the purpose of assuring care or related services pursuant to that
continuing care contract or as full or partial payment for the
promise to provide care for the term of the continuing care contract.
Entrance fee includes the purchase price of a condominium,
cooperative, or other interest sold in connection with a promise of
continuing care. An initial, amortized, or deferred transfer of
consideration that is greater in value than 12 times the monthly
care fee shall be presumed to be an entrance fee.
(4) “Equity” means the value of real property in excess of the
aggregate amount of all liabilities secured by the property.
(5) “Equity interest” means an interest held by a resident in a
continuing care retirement community that consists of either an
ownership interest in any part of the continuing care retirement
community property or a transferable membership that entitles the
holder to reside at the continuing care retirement community.
(6) “Equity project” means a continuing care retirement
community where residents receive an equity interest in the
continuing care retirement community property.
(7) “Equity securities” shall refer generally to large and
midcapitalization corporate stocks that are publicly traded and
readily liquidated for cash, and shall include shares in mutual funds
that hold portfolios consisting predominantly of these stocks and
other qualifying assets, as defined by Section 1792.2. Equity
securities shall also include other similar securities that are
specifically approved by the department.
(8) “Escrow agent” means a bank or institution, including, but
not limited to, a title insurance company, approved by the
department to hold and render accountings for deposits of cash or
cash equivalents.
(f) “Facility” means any place or accommodation where a
provider provides or will provide a resident with care or related
services, whether or not the place or accommodation is constructed,
owned, leased, rented, or otherwise contracted for by the provider.
(g) (reserved)
(h) (reserved)
(i) (1) “Inactive certificate of authority” means a certificate that
has been terminated under Section 1793.8.
(2) “Investment securities” means any of the following:
(A) Direct obligations of the United States, including obligations
issued or held in book-entry form on the books of the United States
Department of the Treasury or obligations the timely payment of
the principal of, and the interest on, which are fully guaranteed by
the United States.
(B) Obligations, debentures, notes, or other evidences of
indebtedness issued or guaranteed by any of the following:
(i) The Federal Home Loan Bank System.
(ii) The Export-Import Bank of the United States.
(v) The Farmer’s Home Administration.
(vi) The Federal Home Loan Mortgage Corporation of the
Federal Housing Administration.
(vii) Any agency, department, or other instrumentality of the United States if the obligations are rated in one of the two highest rating categories of each rating agency rating those obligations.

(C) Bonds of the State of California or of any county, city and county, or city in this state, if rated in one of the two highest rating categories of each rating agency rating those bonds.

(D) Commercial paper of finance companies and banking institutions rated in one of the two highest categories of each rating agency rating those instruments.

(E) Repurchase agreements fully secured by collateral security described in subparagraph (A) or (B), as evidenced by an opinion of counsel, if the collateral is held by the provider or a third party during the term of the repurchase agreement, pursuant to the terms of the agreement, subject to liens or claims of third parties, and has a market value, which is determined at least every 14 days, at least equal to the amount so invested.

(F) Long-term investment agreements, which have maturity dates in excess of one year, with financial institutions, including, but not limited to, banks and insurance companies or their affiliates, if the financial institution’s paying ability for debt obligations or long-term claims or the paying ability of a related guarantor of the financial institution for these obligations or claims, is rated in one of the two highest rating categories of each rating agency rating those instruments, or if the short-term investment agreements are with the financial institution or the related guarantor of the financial institution, the long-term or short-term debt obligations, whichever is applicable, of which are rated in one of the two highest long-term or short-term rating categories, of each rating agency rating the bonds of the financial institution or the related guarantor, provided that if the rating falls below the two highest rating categories, the investment agreement shall allow the provider the option to replace the financial institution or the related guarantor of the financial institution or shall provide for the investment securities to be fully collateralized by investments described in subparagraph (A), and, provided further, if so collateralized, that the provider has a perfected first security lien on the collateral, as evidenced by an opinion of counsel and the collateral is held by the provider.

(G) Banker’s acceptances or certificates of deposit of, or time deposits in, any savings and loan association that meets any of the following criteria:
(i) The debt obligations of the savings and loan association, or in the case of a principal bank, of the bank holding company, are rated in one of the two highest rating categories of each rating agency rating those instruments.

(ii) The certificates of deposit or time deposits are fully insured by the Federal Deposit Insurance Corporation.

(iii) The certificates of deposit or time deposits are secured at all times, in the manner and to the extent provided by law, by collateral security described in subparagraph (A) or (B) with a market value, valued at least quarterly, of no less than the original amount of moneys so invested.

(H) Taxable money market government portfolios restricted to obligations issued or guaranteed as to payment of principal and interest by the full faith and credit of the United States.

(I) Obligations the interest on which is excluded from gross income for federal income tax purposes and money market mutual funds whose portfolios are restricted to these obligations, if the obligations or mutual funds are rated in one of the two highest rating categories by each rating agency rating those obligations.

(J) Bonds that are not issued by the United States or any federal agency, but that are listed on a national exchange and that are rated at least “A” by Moody’s Investors Service, or the equivalent rating by Standard and Poor’s Corporation or Fitch Investors Service.

(K) Bonds not listed on a national exchange that are traded on an over-the-counter basis, and that are rated at least “Aa” by Moody’s Investors Service or “AA” by Standard and Poor’s Corporation or Fitch Investors Service.

(j) (reserved)

(k) (reserved)

(l) “Life care contract” means a continuing care contract that includes a promise, expressed or implied, by a provider to provide or pay for routine services at all levels of care, including acute care and the services of physicians and surgeons, to the extent not covered by other public or private insurance benefits, to a resident for the duration of his or her life. Care shall be provided under a life care contract in a continuing care retirement community having a comprehensive continuum of care, including a skilled nursing facility, under the ownership and supervision of the provider on or adjacent to the premises. No change may be made in the monthly fee based on level of care. A life care contract shall also include
provisions to subsidize residents who become financially unable
to pay their monthly care fees.

(m) (1) “Monthly care fee” means the fee charged to a resident
in a continuing care contract on a monthly or other periodic basis
for current accommodations and services including care, board,
or lodging. Periodic entrance fee payments or other prepayments
shall not be monthly care fees.

(2) “Monthly fee contract” means a continuing care contract
that requires residents to pay monthly care fees.

(n) “Multilevel retirement community” means a long-term care
community or campus that includes independent living services;
assisted living services, as defined in paragraph (5) of subdivision
(a) and skilled nursing services that are provided in a similar
manner as those services are provided within a continuing care
retirement community, provided that the community or campus
does not offer continuing care contracts, and is exempt from this
chapter pursuant to subdivision (b) of Section 1771.3.

(o) “Nonambulatory person” means a person who is unable to
leave a building unassisted under emergency conditions in the
manner described by Section 13131.

(p) (reserved)

(q) (1) “Per capita cost” means a continuing care retirement
community’s operating expenses, excluding depreciation, divided
by the average number of residents.

(2) “Periodic charges” means fees paid by a resident on a
periodic basis.

(3) “Permit to accept deposits” means a written authorization
by the department permitting an applicant to enter into deposit
agreements regarding a single specified continuing care retirement
community.

(4) “Prepaid contract” means a continuing care contract in which
the monthly care fee, if any, may not be adjusted to cover the actual
cost of care and services.

(5) “Preferred access” means that residents who have previously
occupied a residential living unit have a right over other persons
to any assisted living or skilled nursing beds that are available at
the community.
(6) “Processing fee” means a payment to cover administrative costs of processing the application of a depositor or prospective resident.

(7) “Promise to provide one or more elements of care” means any expressed or implied representation that one or more elements of care will be provided or will be available, such as by preferred access.

(8) “Proposes” means a representation that an applicant or provider will or intends to make a future promise to provide care, including a promise that is subject to a condition, such as the construction of a continuing care retirement community or the acquisition of a certificate of authority.

(9) “Provider” means an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. “Provider” also includes any entity that controls an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. The department shall determine whether an entity controls another entity for purposes of this article. No homeowner’s association, cooperative, or condominium association may be a provider.

(10) “Provisional certificate of authority” means the certificate issued by the department, properly executed and bearing the State Seal, under Section 1786. A provisional certificate of authority shall be limited to the specific continuing care retirement community and number of units identified in the applicant’s application.

(q) (reserved)

(r) (1) “Refund reserve” means the reserve a provider is required to maintain, as provided in Section 1792.6.

(2) “Refundable contract” means a continuing care contract that includes a promise, expressed or implied, by the provider to pay an entrance fee refund or to repurchase the transferor’s unit, membership, stock, or other interest in the continuing care retirement community when the promise to refund some or all of the initial entrance fee extends beyond the resident’s sixth year of residency. Providers that enter into refundable contracts shall be subject to the refund reserve requirements of Section 1792.6. A continuing care contract that includes a promise to repay all or a
portion of an entrance fee that is conditioned upon reoccupancy or resale of the unit previously occupied by the resident shall not be considered a refundable contract for purposes of the refund reserve requirements of Section 1792.6, provided that this conditional promise of repayment is not referred to by the applicant or provider as a “refund.”

(3) “Resale fee” means a levy by the provider against the proceeds from the sale of a transferor’s equity interest.

(4) “Reservation fee” refers to consideration collected by an entity that has made a continuing care promise or is proposing to make this promise and has complied with Section 1771.4.

(5) “Resident” means a person who enters into a continuing care contract with a provider, or who is designated in a continuing care contract to be a person being provided or to be provided services, including care, board, or lodging.

(6) “Residential care facility for the elderly” means a housing arrangement as defined by Section 1569.2.

(7) “Residential living unit” means a living unit in a continuing care retirement community that is not used exclusively for assisted living services or nursing services.

(t) (1) “Termination” means the ending of a continuing care contract as provided for in the terms of the continuing care contract.

(2) “Transfer trauma” means death, depression, or regressive behavior, that is caused by the abrupt and involuntary transfer of an elderly resident from one home to another and results from a loss of familiar physical environment, loss of well-known neighbors, attendants, nurses and medical personnel, the stress of an abrupt break in the small routines of daily life, or the loss of visits from friends and relatives who may be unable to reach the new facility.

(3) “Transferor” means a person who transfers, or promises to transfer, consideration in exchange for care and related services under a continuing care contract or proposed continuing care contract, for the benefit of another. A transferor shall have the same rights to cancel and obtain a refund as the depositor under the deposit agreement or the resident under a continuing care contract.
SEC. 3. Section 1771.3 of the Health and Safety Code is amended to read:

1771.3. (a) This chapter shall not apply to either of the following:

(1) An arrangement for the care of a person by a relative.

(2) An arrangement for the care of a person or persons from only one family by a friend.

(b) This chapter shall not apply to any admission or residence agreements offered by residential communities for the elderly or residential care facilities for the elderly that promise residents preferred access to assisted living services or nursing care, when each of the following conditions is satisfied:

(1) Residents pay on a fee-for-service basis for available assisted living services and nursing care.

(2) The fees paid for available assisted living services and nursing care are the same for residents who have previously occupied a residential living unit as for residents who have not previously occupied a residential living unit.

(3) No entrance fee or prepayment for future care or access, other than monthly care fees, is paid by, or charged to, any resident at the community or facility. For purposes of this paragraph, the term entrance fee shall not include initial, deferred, or amortized payments that cumulatively do not exceed ten thousand dollars ($10,000). This maximum shall automatically be adjusted on January 1 of each year to reflect the increase over the prior year in the Consumer Price Index for the Western United States for health care items and services. The adjusted maximum shall be rounded off to the nearest whole dollar. The annual adjustment shall not result in a decrease to the maximum. ($10,000). This maximum shall be adjusted every four years by the department after it has consulted with the continuing care advisory committee and considered changes in the Consumer Price Index for the Western United States, as well as any other economic and industry related factors the department determines to be relevant.

(4) The provider has not made a continuing care promise of preferred access, other than a promise as described in paragraph (5).

(5) The admission or residence agreement states:

(A) “This agreement does not guarantee that an assisted living or nursing bed will be available for residents, but, instead, promises
preferred access to any assisted living or nursing beds that are available at the community or facility. The promise of preferred access gives residents who have previously occupied a residential living unit a right over other persons to such beds.”

(B) “A continuing care contract promises that care will be provided to residents for life or for a term in excess of a year. (Name of community or facility) is not a continuing care retirement community and (name of provider) does not hold a certificate of authority to enter into continuing care contracts and is not required to have the same fiscal reserves as a continuing care provider. This agreement is not a continuing care contract and is exempted from the continuing care statutes under subdivision (b) of Section 1771.3 of the Health and Safety Code so long as the conditions set forth in that section are met.”

(6) The admission or residence agreement also states the policies and procedures regarding transfers to higher levels of care within the community or facility.

(c) Any entity may apply to the department for a Letter of Exemption stating that the requesting entity satisfies the requirements for an exemption under this section.

(d) The department shall issue a Letter of Exemption to a requesting entity if the department determines either of the following:

1. The requesting entity satisfies each of the requirements for an exemption under subdivision (b).

2. The requesting entity satisfies each of the requirements for an exemption under subdivision (b) other than the requirements of paragraph (2) of subdivision (b), and there is no substantial difference between the following:

   A. The fees for available assisted living services and skilled nursing care paid by residents who have previously occupied a residential living unit.

   B. The fees for available assisted living services and skilled nursing care paid by residents who have not previously occupied a residential living unit.

(e) An application to the department for a Letter of Exemption shall include all of the following:

1. A nonrefundable one thousand dollar ($1,000) application fee.

2. The name and business address of the applicant.
(3) A description of the services and care available or provided to residents of the community or facility.

(4) Documentation establishing that the requesting entity satisfies the requirements for an exemption under this section, including all of the following:

(A) A schedule showing all fees for assisted living services and skilled nursing care charged to residents at the facility or community who have previously occupied a residential living unit.

(B) A schedule showing all fees for assisted living services and skilled nursing care charged to residents at the facility or community who have not previously occupied a residential living unit.

(C) A description of the differences between the fees for assisted living services and skilled nursing care charged to residents who have not previously occupied a residential unit and the fees for assisted living services and skilled nursing care charged to residents who have previously occupied a residential unit.

(D) A schedule showing any other fees charged to residents of the community or facility.

(E) Copies of all admission and residence agreement forms that have been entered into, or will be entered into, with residents at the community or facility.

(5) Any other information reasonably requested by the department.

(f) If at any time any of the conditions stated in this section are not satisfied, then the requirements of this chapter apply, and the department may impose appropriate remedies and penalties set forth in Article 7 (commencing with Section 1793.5).

SEC. 4. Section 1771.8 of the Health and Safety Code is amended to read:

1771.8. (a) The Legislature finds and declares all of the following:

(1) The residents of continuing care retirement communities have a unique and valuable perspective on the operations of and services provided in the community in which they live.

(2) Resident input into decisions made by the provider is an important factor in creating an environment of cooperation, reducing conflict, and ensuring timely response and resolution to issues that may arise.
Continuing care retirement communities are strengthened when residents know that their views are heard and respected. The Legislature encourages continuing care retirement communities to exceed the minimum resident participation requirements established by this section by, among other things, the following:

1. Encouraging residents to form a resident association, and assisting the residents, the resident association, and its governing body to keep informed about the operation of the continuing care retirement community.

2. Encouraging residents of a continuing care retirement community or their elected representatives to select residents to participate as board members of the governing body of the provider.

3. Quickly and fairly resolving any dispute, claim, or grievance arising between a resident and the continuing care retirement community.

(c) The governing body of a provider, or the designated representative of the provider, shall hold, at a minimum, semiannual meetings with the residents of the continuing care retirement community, or the resident association or its governing body, for the purpose of the free discussion of subjects including, but not limited to, income, expenditures, and financial trends and issues as they apply to the continuing care retirement community and proposed changes in policies, programs, and services. Nothing in this section precludes a provider from taking action or making a decision at any time, without regard to the meetings required under this subdivision.

(d) At least 30 days prior to the implementation of any increase in the monthly care fee, the designated representative of the provider shall convene a meeting, to which all residents shall be invited, for the purpose of discussing the reasons for the increase, the basis for determining the amount of the increase, and the data used for calculating the increase. This meeting may coincide with the semiannual meetings provided for in subdivision (c). At least 14 days prior to the meeting to discuss any increase in the monthly care fee, the provider shall make available to each resident or resident household comparative data showing the budget for the upcoming year, the current year’s budget, and actual and projected
expenses for the current year, and a copy shall be posted in a conspicuous location at each facility.

(e) The governing body of a provider or the designated representative of the provider shall provide residents with at least 14 days’ advance notice of each meeting provided for in subdivisions (c) and (d), and shall permit residents attending the meeting to present issues orally and in writing. The governing body of a provider or the designated representative of the provider shall post the notice of, and the agenda for, the meeting in a conspicuous place in the continuing care retirement community at least 14 days prior to the meeting. The governing body of a provider or the designated representative of the provider shall make available to residents of the continuing care retirement community upon request the agenda and accompanying materials at least seven days prior to the meeting.

(f) Each provider shall make available to the resident association or its governing body, or if neither exists, to a committee of residents, a financial statement of activities for that facility comparing actual costs to budgeted costs broken down by expense category, not less than semiannually, and shall consult with the resident association or its governing body, or, if neither exists, with a committee of residents, during the annual budget planning process. A financial statement shall also be made available by a provider who operates a continuing care at-home program. The effectiveness of consultations during the annual budget planning process shall be evaluated, at a minimum every two years, by the continuing care retirement community administration. The evaluation, including any policies adopted relating to cooperation with residents, shall be made available to the resident association or its governing body, or, if neither exists, to a committee of residents at least 14 days prior to the next semiannual meeting of residents and the provider’s governing body provided for in subdivision (c), and a copy of the evaluation shall be posted in a conspicuous location at each facility.

(g) Each provider shall, within 10 days after the annual report required pursuant to Section 1790 is submitted to the department, provide, at a central and conspicuous location in the community,
a copy of the annual report, including the multifacility statement of activities, and including a copy of the annual audited financial statement, but excluding personal confidential information.

(h) Each provider shall maintain, as public information, available upon request to residents, prospective residents, and the public, minutes of the board of director’s meetings and shall retain these records for at least three years from the date the records were filed or issued.

(i) The governing body of a provider that is not part of a multifacility organization with more than one continuing care retirement community in the state shall accept at least one resident of the continuing care retirement community it operates to participate as a nonvoting resident representative to the provider’s governing body.

(j) In a multifacility organization having more than one continuing care retirement community in the state, the governing body of the multifacility organization shall elect either to have at least one nonvoting resident representative to the provider’s governing body for each California-based continuing care retirement community the provider operates or to have a resident-elected committee composed of representatives of the residents of each California-based continuing care retirement community that the provider operates select or nominate at least one nonvoting resident representative to the provider’s governing body for every three California-based continuing care retirement communities or fraction thereof that the provider operates. If a multifacility organization elects to have one representative for every three communities that the provider operates, the provider shall provide to the president of the residents association of each of the communities that do not have a resident representative, the same notice of board meetings, board packets, minutes, and other materials as the resident representative. At the reasonable discretion of the provider, information related to litigation, personnel, competitive advantage, or confidential information that is not appropriate to disclose, may be withheld.

(k) In order to encourage innovative and alternative models of resident involvement, a resident selected pursuant to subdivision (i) to participate as a resident representative to the provider’s governing body may, at the option of the resident association, be selected in any one of the following ways:
(1) By a majority vote of the resident association of a provider or by a majority vote of a resident-elected committee of residents of a multifacility organization.

(2) If no resident association exists, any resident may organize a meeting of the majority of the residents of the continuing care retirement community to select or nominate residents to represent them before the governing body.

(3) Any other method designated by the resident association.

(l) The resident association, or organizing resident, or in the case of a multifacility organization, the resident-elected committee of residents, shall give residents of the continuing care retirement community at least 30 days’ advance notice of the meeting to select a resident representative and shall post the notice in a conspicuous place at the continuing care retirement community.

(m) (1) Except as provided in subdivision (n), the resident representative shall receive the same notice of board meetings, board packets, minutes, and other materials as members and shall be permitted to attend, speak, and participate in all meetings of the board.

(2) Resident representatives may share information from board meetings with other residents, unless the information is confidential or doing so would violate fiduciary duties to the provider. In addition, a resident representative shall be permitted to attend meetings of the board committee or committees that review the annual budget of the facility or facilities and recommend increases in monthly care fees. The resident shall receive the same notice of committee meetings, information packets, minutes, and other materials as committee members, and shall be permitted to attend, speak at, and participate in, committee meetings. Resident representatives shall perform their duties in good faith and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.

(n) Notwithstanding subdivision (m), the governing body may exclude resident representatives from its executive sessions and from receiving board materials to be discussed during executive sessions. However, resident representatives shall be included in executive sessions and shall receive all board materials to be discussed during executive sessions related to discussions of the annual budgets, increases in monthly care fees, indebtedness, and
expansion of new and existing continuing care retirement communities.

(o) The provider shall pay all reasonable travel costs for the resident representative.

(p) The provider shall disclose in writing the extent of resident involvement with the board to prospective residents.

(q) Nothing in this section prohibits a provider from exceeding the minimum resident participation requirements of this section by, for example, having more resident meetings or more resident representatives to the board than required or by having one or more residents on the provider’s governing body who are selected with the active involvement of residents.

(r) On or before April 1, 2003, the department, with input from the Continuing Care Advisory Committee of the department established pursuant to Section 1777, shall do all of the following:

(1) Make recommendations to the Legislature as to whether any changes in current law regarding resident representation to the board is needed.

(2) Provide written guidelines available to residents and providers that address issues related to board participation, including rights and responsibilities, and that provide guidance on the extent to which resident representatives who are not voting members of the board have a duty of care, loyalty, and obedience to the provider and the extent to which providers can classify information as confidential and not subject to disclosure by resident representatives to other residents.

SEC. 5. Section 1790 of the Health and Safety Code is amended to read:

1790. (a) Each provider that has obtained a provisional or final certificate of authority and each provider that possesses an inactive certificate of authority shall submit an annual report of its financial condition. The report shall consist of audited financial statements and required reserve calculations, with accompanying certified public accountants’ opinions thereon, the reserve information required by paragraph (2), Continuing Care Provider Fee and Calculation Sheet, evidence of fidelity bond as required by Section 1789.8, and certification that the continuing care contract in use for new residents has been approved by the department, all in a format provided by the department, and shall include all of the following information:
(1) A certification, if applicable, that the entity is maintaining reserves for prepaid continuing care contracts, statutory reserves, and refund reserves.

(2) Full details on the status, description, and amount of all reserves that the provider currently designates and maintains, and on per capita costs of operation for each continuing care retirement community operated.

(3) Disclosure of any funds accumulated for identified projects or purposes and any funds maintained or designated for specific contingencies. Nothing in this subdivision shall be construed to require the accumulation of funds or funding of contingencies, nor shall it be interpreted to alter existing law regarding the reserves that are required to be maintained.

(4) Disclosure, if applicable, of the financial impact of any continuing care at home program operated by the provider, or supported by the provider with either financing or the use of the provider’s continuing care facilities, on the facility’s overall financial health. This disclosure shall include a statement of activities showing the revenue and expense details for the continuing care at-home program.

(5) Full details on any increase in monthly care fees, the basis for determining the increase, and the data used to calculate the increase.

(6) The required reserve calculation schedules shall be accompanied by the auditor’s opinion as to compliance with applicable statutes.

(7) Any other information as the department may require.

(b) Each provider shall file the annual report with the department within four months after the provider’s fiscal yearend. If the complete annual report is not received by the due date, a one thousand dollar ($1,000) late fee shall accompany submission of the reports. If the reports are more than 30 days past due, an additional fee of thirty-three dollars ($33) for each day over the first 30 days shall accompany submission of the report. The department may, at its discretion, waive the late fee for good cause.

(c) The annual report and any amendments thereto shall be signed and certified by the chief executive officer of the provider, stating that, to the best of his or her knowledge and belief, the items are correct.
(d) A copy of the most recent annual audited financial statement shall be transmitted by the provider to each transferor requesting the statement.

(e) A provider shall amend its annual report on file with the department at any time, without the payment of any additional fee, if an amendment is necessary to prevent the report from containing a material misstatement of fact or omitting a material fact.

(f) If a provider is no longer entering into continuing care contracts, and currently is caring for 10 or fewer continuing care residents, the provider may request permission from the department, in lieu of filing the annual report, to establish a trust fund or to secure a performance bond to ensure fulfillment of continuing care contract obligations. The request shall be made each year within 30 days after the provider’s fiscal yearend. The request shall include the amount of the trust fund or performance bond determined by calculating the projected life costs, less the projected life revenue, for the remaining continuing care residents in the year the provider requests the waiver. If the department approves the request, the following shall be submitted to the department annually:

1. Evidence of trust fund or performance bond and its amount.
2. A list of continuing care residents. If the number of continuing care residents exceeds 10 at any time, the provider shall comply with the requirements of this section.
3. A provider fee as required by subdivision (c) of Section 1791.

(g) If the department determines a provider’s annual audited report needs further analysis and investigation, as a result of incomplete and inaccurate financial statements, significant financial deficiencies, development of workout plans to stabilize financial solvency, or for any other reason, the provider shall reimburse the department for reasonable actual costs incurred by the department or its representative. The reimbursed funds shall be deposited in the Continuing Care Contract Provider Fee Fund.

SEC. 6. Section 1793.63 is added to the Health and Safety Code, to read:

1793.63. (a) A provider of a continuing care at home program shall comply with all of the following:
(1) The provider shall file an abbreviated application, including, but not limited to, feasibility information, for approval by the department.

(2) The provider shall hold a certificate of authority issued by the department authorizing the program to enter into continuing care contracts.

(1) Hold a certificate of authority issued by the department authorizing the provider to enter into continuing care contracts.

(2) File an abbreviated application to commence and operate the program to the department for approval. The application shall include, but not be limited to, all of the following:

(A) A description of the proposed continuing care at home program, including the target market, the types of service to be provided, and the fees to be charged.

(B) The intended use of the provider’s continuing care retirement community to furnish services to continuing care at-home residents.

(C) Information showing the financial feasibility of the continuing care at-home program and the program’s financial impact on the provider and its continuing care facility or facilities.

(D) A sample copy of the proposed written service agreement.

(3) Conduct actuarial analyses that present the impact of the continuing care at-home program on the overall operation of the continuing care retirement community and make this information available to all residents.

(3) The provider shall enter

(4) Enter into a written service agreement, approved by the department, with each of its continuing care at-home clients. The service agreement shall include, but need not be limited to, provisions setting forth all of the following:

(A) A description of the services to be provided.

(B) The fees to be paid by the client, including, but not limited to, a description of, and the basis for, any potential increase in those fees.

(C) The grounds for termination of the service agreement, and the grounds upon which the provider may recommend that the client be transferred to another facility.

(D) The duration of the service agreement.

(5) Disclose to residents information regarding which locations of the continuing care retirement community will be made available
to continuing care at home participants prior to operating the program.

(4) (b) (1) The provider may, with the consent of the client or his or her legal representative, transfer the client to an appropriate licensed health facility or residential care facility if the client’s health or care needs exceed the provider’s ability to provide needed services, or exceed the provider’s authorized scope of services.

(5) The provider shall conduct an assessment of the resident’s service needs upon the initiation of service. The assessment shall be updated annually thereafter, or sooner if a significant change in the client’s health or mental status occurs.

(6) The provider shall conduct actuarial analyses that present the impact of the continuing care at home program on the overall operation of the continuing care retirement community or multilevel retirement community and shall make this information available to all residents.

(7) (2) The provider may provide services, as specified in the service agreement, in the facility or through an appropriately credentialed third party subject to space availability. Continuing care retirement community residents will be given priority over continuing care at home residents when applying for skilled nursing services.

(8) (3) The provider shall disclose to residents information regarding which locations of the continuing care retirement community or multilevel retirement community will be made available to continuing care at home participants prior to the operation of the program.

(c) A provider of a continuing care at home program may do all of the following:

(1) Furnish one or more services to an elderly person in the elderly person’s own private residence, including, but not limited to the following:

(A) Remote monitoring.

(B) Assistance with bathing, dressing, or grooming.
(C) Assistance with the storage and administration of medications.

(D) Meals, housekeeping, laundry, home maintenance, grounds maintenance, companionship, social activities, recreational activities, and referrals to other care and service providers.

(2) Furnish, at the provider’s discretion, additional services on the provider’s campus, as appropriate. This paragraph does not authorize provision of services by an unlicensed person or in an unlicensed setting, if those services are otherwise required by law to be provided by a licensed person or in a licensed setting.

authorize an unlicensed person to provide services, or services to be provided in an unlicensed setting, if a license or licensed setting is otherwise required by law.

(3) Furnish any additional supportive services in an elderly person’s private home as specified in the service agreement within the limits of licensure, as required. the service agreement in a manner that is consistent with the licensing statutes and regulations.

(4) Establish, at its discretion, within the private residence of the elderly person, a smoke detection system, a fire alarm, a fire suppression sprinkler system, a medical alert system, a system for routine inspections, and other safety features.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.