

## Senate Bill No. 135

### CHAPTER 673

An act to amend Sections 1250, 1250.1, 1266, 1599, 1599.1, 1599.4, 1746, 1795, 128755, and 129725 of, and to add Article 10.6 (commencing with Section 1339.40) to Chapter 2 of Division 2 to, the Health and Safety Code, relating to hospice care.

[Approved by Governor September 27, 2012. Filed with  
Secretary of State September 27, 2012.]

#### LEGISLATIVE COUNSEL'S DIGEST

SB 135, Hernandez. Hospice facilities.

Under existing law, the State Department of Public Health licenses and regulates health facilities, including skilled nursing facilities, intermediate care facilities, and congregate living health facilities. Under existing law, the department also licenses and regulates hospices and the provision of hospice services. Violation of these provisions is a crime.

This bill would create a new health facility licensing category for, and would require the department to develop regulations governing licensure of, hospice facilities, as defined. It would impose various requirements on these facilities.

This bill would exclude a freestanding building used, or designed to be used, as a congregate living health facility or as a hospice facility from the definition of a hospital building for purposes of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

Because this bill would create a new crime, it would impose a state-mandated local program.

This bill would incorporate additional changes in Section 1250 of the Health and Safety Code, proposed by SB 1228 to be operative only if SB 1228 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last. The bill would also incorporate additional changes in Section 1266 of the Health and Safety Code, proposed by AB 1710 to be operative only if AB 1710 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last.

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.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Hospice is a special type of health care service designed to provide palliative care and to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to terminal illness.

(b) Hospice services provide supportive care to the primary caregiver and family of the patient.

(c) Hospice services are provided primarily in the home, but can also be provided in residential care or in health facility inpatient settings.

(d) Persons who do not have family members or caregivers who are able to provide care in the home should be able to have care provided in a homelike environment, rather than in an institutional setting, if that is their preference.

(e) Permitting the establishment of licensed hospice facilities provides additional care and treatment options for persons who are at the end of life.

(f) The establishment of licensed hospice facilities is permitted under federal law and by many other states.

(g) Permitting the establishment of licensed hospice facilities is consistent with federal legal affirmations of the right of an individual to refuse life-sustaining treatment and that each person's preferences about his or her end-of-life care should be considered.

(h) Permitting the establishment of licensed hospice facilities is also consistent with the decision of the United States Supreme Court in *Olmstead v. L.C. by Zimring* (1999) 527 U.S. 581, which held that persons with disabilities have the right to live in the most integrated setting possible with appropriate access to care and choice of community-based services and placement options.

(i) It is the intent of the Legislature to permit the licensure of hospice inpatient facilities in order to improve access to care, to provide additional care options, and to provide for a homelike environment within which to provide care and treatment for persons who are experiencing the last phases of life.

SEC. 2. Section 1250 of the Health and Safety Code is amended to read:

1250. As used in this chapter, "health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

(a) "General acute care hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general

acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section.

A “general acute care hospital” includes a “rural general acute care hospital.” However, a “rural general acute care hospital” shall not be required by the department to provide surgery and anesthesia services. A “rural general acute care hospital” shall meet either of the following conditions:

(1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982.

(2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

(b) “Acute psychiatric hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(c) “Skilled nursing facility” means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(d) “Intermediate care facility” means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

(e) “Intermediate care facility/developmentally disabled habilitative” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

(f) “Special hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

(g) “Intermediate care facility/developmentally disabled” means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

(h) “Intermediate care facility/developmentally disabled-nursing” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons with developmental disabilities or who demonstrate significant developmental delay that may lead to a developmental disability if not treated.

(i) (1) “Congregate living health facility” means a residential home with a capacity, except as provided in paragraph (4), of no more than 12 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

(2) Congregate living health facilities shall provide one of the following services:

(A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

(B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A “life-threatening illness” means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

(C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person

whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

(3) A congregate living health facility license shall specify which of the types of persons described in paragraph (2) to whom a facility is licensed to provide services.

(4) (A) A facility operated by a city and county for the purposes of delivering services under this section may have a capacity of 59 beds.

(B) A congregate living health facility not operated by a city and county servicing persons who are terminally ill, persons who have been diagnosed with a life-threatening illness, or both, that is located in a county with a population of 500,000 or more persons, or located in a county of the 16th class pursuant to Section 28020 of the Government Code, may have not more than 25 beds for the purpose of serving persons who are terminally ill.

(C) A congregate living health facility not operated by a city and county serving persons who are catastrophically and severely disabled, as defined in subparagraph (C) of paragraph (2) that is located in a county of 500,000 or more persons may have not more than 12 beds for the purpose of serving persons who are catastrophically and severely disabled.

(5) A congregate living health facility shall have a noninstitutional, homelike environment.

(j) (1) “Correctional treatment center” means a health facility operated by the Department of Corrections and Rehabilitation, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by the department, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services. This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards who may be receiving outpatient services and are housed separately for reasons of improved access to health care, security, and protection. The health services provided by a correctional treatment center shall include, but are not limited to, all of the following basic services: physician and surgeon, psychiatrist, psychologist, nursing, pharmacy, and dietary. A correctional treatment center may provide the following services: laboratory, radiology, perinatal, and any other services approved by the department.

(2) Outpatient surgical care with anesthesia may be provided, if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204, with the exception of the requirement that patients remain less than 24 hours.

(3) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

(4) Physician and surgeon services shall be readily available in a correctional treatment center on a 24-hour basis.

(5) It is not the intent of the Legislature to have a correctional treatment center supplant the general acute care hospitals at the California Medical Facility, the California Men's Colony, and the California Institution for Men. This subdivision shall not be construed to prohibit the Department of Corrections and Rehabilitation from obtaining a correctional treatment center license at these sites.

(k) "Nursing facility" means a health facility licensed pursuant to this chapter that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the federal Social Security Act or as a nursing facility in the federal Medicaid Program under Title XIX of the federal Social Security Act, or as both.

(l) Regulations defining a correctional treatment center described in subdivision (j) that is operated by a county, city, or city and county, the Department of Corrections and Rehabilitation, or the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall not become effective prior to, or if effective, shall be inoperative until January 1, 1996, and until that time these correctional facilities are exempt from any licensing requirements.

(m) "Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)" means a homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. ICF/DD-CN facilities shall be subject to licensure under this chapter upon adoption of licensing regulations in accordance with Section 1275.3. A facility providing continuous skilled nursing services to persons with developmental disabilities pursuant to Section 14132.20 or 14495.10 of the Welfare and Institutions Code shall apply for licensure under this subdivision within 90 days after the regulations become effective, and may continue to operate pursuant to those sections until its licensure application is either approved or denied.

(n) "Hospice facility" means a health facility licensed pursuant to this chapter, with a capacity of no more than 24 beds that provides hospice services. Hospice services include, but are not limited to, routine care, continuous care, inpatient respite care, and inpatient hospice care as defined in subdivision (d) of Section 1339.40, and is operated by a provider of hospice services that is licensed pursuant to Section 1751 and certified as a hospice pursuant to Part 418 of Title 42 of the Code of Federal Regulations.

SEC. 2.5. Section 1250 of the Health and Safety Code is amended to read:

1250. As used in this chapter, "health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis,

care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

(a) “General acute care hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section.

A “general acute care hospital” includes a “rural general acute care hospital.” However, a “rural general acute care hospital” shall not be required by the department to provide surgery and anesthesia services. A “rural general acute care hospital” shall meet either of the following conditions:

(1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982.

(2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

(b) “Acute psychiatric hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing

with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(c) (1) “Skilled nursing facility” means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(2) “Skilled nursing facility” includes a “small house skilled nursing facility (SHSNF),” as defined in Section 1323.5.

(d) “Intermediate care facility” means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

(e) “Intermediate care facility/developmentally disabled habilitative” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

(f) “Special hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

(g) “Intermediate care facility/developmentally disabled” means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

(h) “Intermediate care facility/developmentally disabled-nursing” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons with developmental disabilities or who demonstrate significant developmental delay that may lead to a developmental disability if not treated.

(i) (1) “Congregate living health facility” means a residential home with a capacity, except as provided in paragraph (4), of no more than 12 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

(2) Congregate living health facilities shall provide one of the following services:

(A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

(B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A “life-threatening illness” means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

(C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

(3) A congregate living health facility license shall specify which of the types of persons described in paragraph (2) to whom a facility is licensed to provide services.

(4) (A) A facility operated by a city and county for the purposes of delivering services under this section may have a capacity of 59 beds.

(B) A congregate living health facility not operated by a city and county servicing persons who are terminally ill, persons who have been diagnosed with a life-threatening illness, or both, that is located in a county with a population of 500,000 or more persons, or located in a county of the 16th class pursuant to Section 28020 of the Government Code, may have not more than 25 beds for the purpose of serving persons who are terminally ill.

(C) A congregate living health facility not operated by a city and county serving persons who are catastrophically and severely disabled, as defined in subparagraph (C) of paragraph (2) that is located in a county of 500,000 or more persons may have not more than 12 beds for the purpose of serving persons who are catastrophically and severely disabled.

(5) A congregate living health facility shall have a noninstitutional, homelike environment.

(j) (1) “Correctional treatment center” means a health facility operated by the Department of Corrections and Rehabilitation, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by the department, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services. This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards who may be receiving outpatient services and are housed separately for reasons of improved access to health care, security,

and protection. The health services provided by a correctional treatment center shall include, but are not limited to, all of the following basic services: physician and surgeon, psychiatrist, psychologist, nursing, pharmacy, and dietary. A correctional treatment center may provide the following services: laboratory, radiology, perinatal, and any other services approved by the department.

(2) Outpatient surgical care with anesthesia may be provided, if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204, with the exception of the requirement that patients remain less than 24 hours.

(3) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

(4) Physician and surgeon services shall be readily available in a correctional treatment center on a 24-hour basis.

(5) It is not the intent of the Legislature to have a correctional treatment center supplant the general acute care hospitals at the California Medical Facility, the California Men's Colony, and the California Institution for Men. This subdivision shall not be construed to prohibit the Department of Corrections and Rehabilitation from obtaining a correctional treatment center license at these sites.

(k) "Nursing facility" means a health facility licensed pursuant to this chapter that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) or as a nursing facility in the federal Medicaid Program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or as both.

(l) Regulations defining a correctional treatment center described in subdivision (j) that is operated by a county, city, or city and county, the Department of Corrections and Rehabilitation, or the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall not become effective prior to, or if effective, shall be inoperative until January 1, 1996, and until that time these correctional facilities are exempt from any licensing requirements.

(m) "Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)" means a homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. ICF/DD-CN facilities shall be subject to licensure under this chapter upon adoption of licensing regulations in accordance with Section 1275.3. A facility providing continuous skilled nursing services to persons with developmental disabilities pursuant to Section 14132.20 or 14495.10 of the Welfare and Institutions Code shall

apply for licensure under this subdivision within 90 days after the regulations become effective, and may continue to operate pursuant to those sections until its licensure application is either approved or denied.

(n) “Hospice facility” means a health facility licensed pursuant to this chapter with a capacity of no more than 24 beds that provides hospice services. Hospice services include, but are not limited to, routine care, continuous care, inpatient respite care, and inpatient hospice care as defined in subdivision (d) of Section 1339.40, and is operated by a provider of hospice services that is licensed pursuant to Section 1751 and certified as a hospice pursuant to Part 418 of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 1250.1 of the Health and Safety Code is amended to read:

1250.1. (a) The department shall adopt regulations that define all of the following bed classifications for health facilities:

- (1) General acute care.
- (2) Skilled nursing.
- (3) Intermediate care—developmental disabilities.
- (4) Intermediate care—other.
- (5) Acute psychiatric.
- (6) Specialized care, with respect to special hospitals only.
- (7) Chemical dependency recovery.
- (8) Intermediate care facility/developmentally disabled habilitative.
- (9) Intermediate care facility/developmentally disabled nursing.
- (10) Congregate living health facility.
- (11) Pediatric day health and respite care facility, as defined in Section 1760.2.
- (12) Correctional treatment center. For correctional treatment centers that provide psychiatric and psychological services provided by county mental health agencies in local detention facilities, the State Department of State Hospitals shall adopt regulations specifying acute and nonacute levels of 24-hour care. Licensed inpatient beds in a correctional treatment center shall be used only for the purpose of providing health services.
- (13) Hospice facility.

(b) Except as provided in Section 1253.1, beds classified as intermediate care beds, on September 27, 1978, shall be reclassified by the department as intermediate care—other. This reclassification shall not constitute a “project” within the meaning of Section 127170 and shall not be subject to any requirement for a certificate of need under Chapter 1 (commencing with Section 127125) of Part 2 of Division 107, and regulations of the department governing intermediate care prior to the effective date shall continue to be applicable to the intermediate care—other classification unless and until amended or repealed by the department.

SEC. 4. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) The Licensing and Certification Division shall be supported entirely by federal funds and special funds by no earlier than the beginning of the 2009–10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual

Budget Act or other enacted legislation. For the 2007–08 fiscal year, General Fund support shall be provided to offset licensing and certification fees in an amount of not less than two million seven hundred eighty-two thousand dollars (\$2,782,000).

(b) (1) The Licensing and Certification Program fees for the 2006–07 fiscal year shall be as follows:

Type of Facility	Fee	
General Acute Care Hospitals	\$ 134.10	per bed
Acute Psychiatric Hospitals	\$ 134.10	per bed
Special Hospitals	\$ 134.10	per bed
Chemical Dependency Recovery Hospitals	\$ 123.52	per bed
Skilled Nursing Facilities	\$ 202.96	per bed
Intermediate Care Facilities	\$ 202.96	per bed
Intermediate Care Facilities - Developmentally Disabled	\$ 592.29	per bed
Intermediate Care Facilities - Developmentally Disabled - Habilitative	\$1,000.00	per facility
Intermediate Care Facilities - Developmentally Disabled - Nursing	\$1,000.00	per facility
Home Health Agencies	\$2,700.00	per facility
Referral Agencies	\$5,537.71	per facility
Adult Day Health Centers	\$4,650.02	per facility
Congregate Living Health Facilities	\$ 202.96	per bed
Psychology Clinics	\$ 600.00	per facility
Primary Clinics - Community and Free Specialty Clinics - Rehab Clinics (For profit)	\$2,974.43	per facility
(Nonprofit)	\$ 500.00	per facility
Specialty Clinics - Surgical and Chronic	\$1,500.00	per facility
Dialysis Clinics	\$1,500.00	per facility
Pediatric Day Health/Respite Care	\$ 142.43	per bed
Alternative Birthing Centers	\$2,437.86	per facility
Hospice	\$1,000.00	per provider
Correctional Treatment Centers	\$ 590.39	per bed

(2) (A) In the first year of licensure for intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) facilities, the licensure fee for those facilities shall be equivalent to the licensure fee for intermediate care facility/developmentally disabled-nursing facilities during the same year. Thereafter, the licensure fee for ICF/DD-CN facilities shall be established pursuant to the same procedures described in this section.

(B) In the first year of licensure for hospice facilities, the licensure fee shall be equivalent to the licensure fee for congregate living health facilities during the same year. Thereafter, the licensure fee for hospice facilities shall be established pursuant to the same procedures described in this section.

(c) Commencing February 1, 2007, and every February 1 thereafter, the department shall publish a list of estimated fees pursuant to this section. The calculation of estimated fees and the publication of the report and list of estimated fees shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) By February 1 of each year, the department shall prepare the following reports and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (c), available to the public by submitting them to the Legislature and posting them on the department's Internet Web site:

(1) The department shall prepare a report of all costs for activities of the Licensing and Certification Program. At a minimum, this report shall include a narrative of all baseline adjustments and their calculations, a description of how each category of facility was calculated, descriptions of assumptions used in any calculations, and shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category, including workload costs for facility categories that have been established by statute and for which licensing regulations and procedures are under development.

(B) Cost estimates, and the estimated fees, shall be based on the appropriation amounts in the Governor's proposed budget for the next fiscal year, with and without policy adjustments to the fee methodology.

(C) The allocation of program, operational, and administrative overhead, and indirect costs to fee categories shall be based on generally accepted cost allocation methods. Significant items of costs shall be directly charged to fee categories if the expenses can be reasonably identified to the fee category that caused them. Indirect and overhead costs shall be allocated to all fee categories using a generally accepted cost allocation method.

(D) The amount of federal funds and General Fund moneys to be received in the budget year shall be estimated and allocated to each fee category based upon an appropriate metric.

(E) The fee for each category shall be determined by dividing the aggregate state share of all costs for the Licensing and Certification Program by the appropriate metric for the category of licensure. Amounts actually received for new licensure applications, including change of ownership applications, and late payment penalties, pursuant to Section 1266.5, during each fiscal year shall be calculated and 95 percent shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds. The remaining 5 percent shall be retained in the fund as a reserve until appropriated.

(2) (A) The department shall prepare a staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey

schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

(B) The analysis under this paragraph shall be made available to interested persons and shall include all of the following:

(i) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(ii) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(iii) The number of facilities receiving full surveys and the frequency and number of followup visits.

(iv) The number and timeliness of complaint investigations.

(v) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(vi) Other applicable activities of the licensing and certification division.

(e) (1) The department shall adjust the list of estimated fees published pursuant to subdivision (c) if the annual Budget Act or other enacted legislation includes an appropriation that differs from those proposed in the Governor's proposed budget for that fiscal year.

(2) The department shall publish a final fee list, with an explanation of any adjustment, by the issuance of an all facilities letter, by posting the list on the department's Internet Web site, and by including the final fee list as part of the licensing application package, within 14 days of the enactment of the annual Budget Act. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) (1) Fees shall not be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. Fees shall not be assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(2) For the 2006–07 state fiscal year, a fee shall not be assessed or collected pursuant to this section from any general acute care hospital owned by a health care district with 100 beds or less.

(g) The Licensing and Certification Program may change annual license expiration renewal dates to provide for efficiencies in operational processes or to provide for sufficient cashflow to pay for expenditures. If an annual license expiration date is changed, the renewal fee shall be prorated accordingly. Facilities shall be provided with a 60-day notice of any change in their annual license renewal date.

SEC. 4.5. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) The Licensing and Certification Division shall be supported entirely by federal funds and special funds by no earlier than the beginning of the 2009–10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation. For the 2007–08 fiscal year, General Fund support shall be provided to offset licensing and certification fees in an amount of not less than two million seven hundred eighty-two thousand dollars (\$2,782,000).

(b) (1) The Licensing and Certification Program fees for the 2006–07 fiscal year shall be as follows:

Type of Facility	Fee	
General Acute Care Hospitals	\$ 134.10	per bed
Acute Psychiatric Hospitals	\$ 134.10	per bed
Special Hospitals	\$ 134.10	per bed
Chemical Dependency Recovery Hospitals	\$ 123.52	per bed
Skilled Nursing Facilities	\$ 202.96	per bed
Intermediate Care Facilities	\$ 202.96	per bed
Intermediate Care Facilities- Developmentally Disabled	\$ 592.29	per bed
Intermediate Care Facilities- Developmentally Disabled-Habilitative	\$1,000.00	per facility
Intermediate Care Facilities- Developmentally Disabled-Nursing	\$1,000.00	per facility
Home Health Agencies	\$2,700.00	per facility
Referral Agencies	\$5,537.71	per facility
Adult Day Health Centers	\$4,650.02	per facility
Congregate Living Health Facilities	\$ 202.96	per bed
Psychology Clinics	\$ 600.00	per facility
Primary Clinics- Community and Free Specialty Clinics- Rehab Clinics	\$ 600.00	per facility
(For profit)	\$2,974.43	per facility
(Nonprofit)	\$ 500.00	per facility
Specialty Clinics- Surgical and Chronic	\$1,500.00	per facility
Dialysis Clinics	\$1,500.00	per facility
Pediatric Day Health/Respite Care	\$ 142.43	per bed
Alternative Birthing Centers	\$2,437.86	per facility
Hospice	\$1,000.00	per provider
Correctional Treatment Centers	\$ 590.39	per bed

(2) (A) In the first year of licensure for intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) facilities, the licensure fee for those facilities shall be equivalent to the licensure fee for intermediate care facility/developmentally disabled-nursing facilities during the same year. Thereafter, the licensure fee for ICF/DD-CN facilities shall be established pursuant to the same procedures described in this section.

(B) In the first year of licensure for hospice facilities, the licensure fee shall be equivalent to the licensure fee for congregate living health facilities during the same year. Thereafter, the licensure fee for hospice facilities shall be established pursuant to the same procedures described in this section.

(c) Commencing February 1, 2007, and every February 1 thereafter, the department shall publish a list of estimated fees pursuant to this section. The calculation of estimated fees and the publication of the report and list of estimated fees shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Notwithstanding Section 10231.5 of the Government Code, by February 1 of each year, the department shall prepare the following reports and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (c), available to the public by submitting them to the Legislature and posting them on the department's Internet Web site:

(1) A report of all costs for activities of the Licensing and Certification Program. At a minimum, this report shall include a narrative of all baseline adjustments and their calculations, a description of how each category of facility was calculated, descriptions of assumptions used in any calculations, and shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category, including workload costs for facility categories that have been established by statute and for which licensing regulations and procedures are under development.

(B) Cost estimates, and the estimated fees, shall be based on the appropriation amounts in the Governor's proposed budget for the next fiscal year, with and without policy adjustments to the fee methodology.

(C) The allocation of program, operational, and administrative overhead, and indirect costs to fee categories shall be based on generally accepted cost allocation methods. Significant items of costs shall be directly charged to fee categories if the expenses can be reasonably identified to the fee category that caused them. Indirect and overhead costs shall be allocated to all fee categories using a generally accepted cost allocation method.

(D) The amount of federal funds and General Fund moneys to be received in the budget year shall be estimated and allocated to each fee category based upon an appropriate metric.

(E) The fee for each category shall be determined by dividing the aggregate state share of all costs for the Licensing and Certification Program by the appropriate metric for the category of licensure. Amounts actually received for new licensure applications, including change of ownership applications, and late payment penalties, pursuant to Section 1266.5, during each fiscal year shall be calculated and 95 percent shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds.

The remaining 5 percent shall be retained in the fund as a reserve until appropriated.

(2) (A) A staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

(B) The analysis under this paragraph shall be made available to interested persons and shall include all of the following:

(i) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(ii) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(iii) The number of facilities receiving full surveys and the frequency and number of followup visits.

(iv) The number and timeliness of complaint investigations.

(v) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(vi) Other applicable activities of the licensing and certification division.

(3) The annual program fee report described in subdivision (d) of Section 1416.36.

(e) The reports required pursuant to subdivision (d) shall be submitted in compliance with Section 9795 of the Government Code.

(f) (1) The department shall adjust the list of estimated fees published pursuant to subdivision (c) if the annual Budget Act or other enacted legislation includes an appropriation that differs from those proposed in the Governor's proposed budget for that fiscal year.

(2) The department shall publish a final fee list, with an explanation of any adjustment, by the issuance of an all facilities letter, by posting the list on the department's Internet Web site, and by including the final fee list as part of the licensing application package, within 14 days of the enactment of the annual Budget Act. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) (1) Fees shall not be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. Fees shall not be assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(2) For the 2006–07 state fiscal year, a fee shall not be assessed or collected pursuant to this section from any general acute care hospital owned by a health care district with 100 beds or less.

(h) The Licensing and Certification Program may change annual license expiration renewal dates to provide for efficiencies in operational processes or to provide for sufficient cashflow to pay for expenditures. If an annual license expiration date is changed, the renewal fee shall be prorated accordingly. Facilities shall be provided with a 60-day notice of any change in their annual license renewal date.

SEC. 5. Article 10.6 (commencing with Section 1339.40) is added to Chapter 2 of Division 2 of the Health and Safety Code, to read:

#### Article 10.6. Hospice Licensing

1339.40. For the purposes of this article, the following definitions apply:

(a) “Bereavement services” has the same meaning as defined in subdivision (a) of Section 1746.

(b) “Hospice care” means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the following criteria:

(1) Considers the patient and the patient’s family, in addition to the patient, as the unit of care.

(2) Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the patient and the patient’s family.

(3) Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care that emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services. Limited inpatient services are intended to ensure both continuity of care and appropriateness of services for those patients who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

(4) Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

(5) Provides for bereavement services following death to assist the family in coping with social and emotional needs associated with the death of the patient.

(6) Actively utilizes volunteers in the delivery of hospice services.

(7) To the extent appropriate, based on the medical needs of the patient, provides services in the patient’s home or primary place of residence.

(c) “Hospice facility” means a health facility as defined in subdivision (n) of Section 1250.

(d) “Inpatient hospice care” means hospice care that is provided to patients in a hospice facility, including routine, continuous and inpatient care directly as specified in Section 418.10 of Title 42 of the Code of Federal

Regulations, and may include short-term inpatient respite care as specified in Section 418.108 of Title 42 of the Code of Federal Regulations.

(e) “Interdisciplinary team” has the same meaning as defined in subdivision (g) of Section 1746.

(f) “Medical direction” has the same meaning as defined in subdivision (h) of Section 1746.

(g) “Palliative care” has the same meaning as defined in subdivision (j) of Section 1746.

(h) “Plan of care” has the same meaning as defined in subdivision (l) of Section 1746.

(i) “Skilled nursing services” has the same meaning as defined in subdivision (n) of Section 1746.

(j) “Social services/counseling services” has the same meaning as defined in subdivision (o) of Section 1746.

(k) “Terminal disease” or “terminal illness” has the same meaning as defined in subdivision (p) of Section 1746.

(l) “Volunteer services” has the same meaning as defined in subdivision (q) of Section 1746.

1339.41. (a) A person, governmental agency, or political subdivision of the state shall not be licensed as a hospice facility under this chapter unless the person or entity is a provider of hospice services licensed pursuant to Section 1751 and is certified as a hospice facility under Part 418 of Title 42 of the Code of Federal Regulations.

(b) A hospice provider that intends to provide inpatient hospice care in the hospice provider’s own facility shall submit an application and fee for licensure as a hospice facility under this chapter. Notwithstanding the maximum period for a provisional license under subdivision (b) of Section 1268.5, the department may issue a provisional license to a hospice facility for a period of up to one year.

(c) A verified application for a new license completed on forms furnished by the department shall be submitted to the department upon the occurrence of either of the following:

- (1) Establishment of a hospice facility.
- (2) Change of ownership.

(d) The licensee shall submit to the department a verified application for a corrected license completed on forms furnished by the department upon the occurrence of any of the following:

- (1) Construction of new or replacement hospice facility.
- (2) Increase in licensed bed capacity.
- (3) Change of name of facility.
- (4) Change of licensed category.
- (5) Change of location of facility.
- (6) Change in bed classification.

(e) (1) A hospice facility that participates in the Medicare and Medicaid Programs may obtain initial certification from a federal Centers for Medicare and Medicaid Services (CMS) approved accreditation organization.

(2) If the CMS-approved accreditation organization conducts certification inspections, the hospice facility shall transmit to the department, within 30 days of receipt, a copy of the final accreditation report of the accreditation organization.

(f) A hospice facility shall be separately licensed, irrespective of the location of the facility.

(g) (1) The licensee shall notify the department in writing of any changes in the information provided pursuant to subdivision (d) within 10 days of these changes. This notice shall include information and documentation regarding the changes.

(2) Each licensee shall notify the department within 10 days in writing of any change of the mailing address of the licensee. This notice shall include the new mailing address of the licensee.

(3) When a change in the principal officer of a corporate licensee, including the chairman, president, or general manager occurs, the licensee shall notify the department of this change within 10 days in writing. This notice shall include the name and business address of the officer.

(4) Any decrease in licensed bed capacity of the facility shall require notification by letter to the department and shall result in the issuance of a corrected license.

1339.42. (a) No private or public organization, including, but not limited to, any partnership, corporation, or political subdivision of the state, or other governmental agency within the state, shall do any of the following without a license issued pursuant to this chapter:

(1) Represent itself to be a hospice facility by its name or advertisement, soliciting, or any other presentments to the public, or in the context of services within the scope of this chapter imply that it is licensed to provide those services or to make any reference to employee bonding in relation to those services.

(2) Use the words “hospice facility,” “hospice home,” “hospice-facility,” or any combination of those terms, within its name.

(3) Use words to imply that it is licensed as a hospice facility to provide those services.

(b) A hospice facility licensee shall obtain criminal background checks for its employees, volunteers, and contractors in accordance with federal Medicare conditions of participation (42 C.F.R. Part 418 et seq.) and as may be required in accordance with state law. The hospice facility licensee shall pay the costs of obtaining a criminal background check.

1339.43. (a) A hospice facility shall provide a home-like environment that is comfortable and accommodating to both the patient and patient’s visitors.

(b) Building standards for hospice facilities adopted pursuant to this chapter relating to fire and panic safety, and other regulations for hospice facilities adopted pursuant to this chapter, shall apply uniformly throughout the state. No city, county, city and county, including a charter city or charter county, or fire protection district shall adopt or enforce any ordinance or local rule or regulation relating to fire and panic safety in buildings or

structures subject to this section that is inconsistent with the rules and regulations for hospice facilities adopted pursuant to this chapter.

(c) The hospice facility shall meet the fire protection standards set forth in the federal Medicare conditions of participation (42 C.F.R. Part 418 et seq.).

(d) A hospice facility may operate as a freestanding health facility.

(1) Until the Office of Statewide Health Planning and Development, in consultation with the Office of the State Fire Marshal, develops and adopts building standards for hospice facilities, a freestanding hospice facility shall meet applicable building standards and requirements relating to the physical environment of the facility as specified in Section 418.100 of Title 42 of the Code of Federal Regulations. The building standards developed shall, at a minimum, maintain the requirements specified in that section.

(2) A freestanding hospice facility shall be under the jurisdiction of the local building department. As part of the license application, the prospective licensee shall submit evidence of compliance with applicable building standards for hospice facilities.

(3) The physical environment of the hospice facility shall be adequate to provide the level of care and service required by the residents of the facility as determined by the department.

(e) A hospice facility may be located within the physical plant of another health facility.

(1) Notwithstanding subdivision (d) and paragraphs (8) and (9) of subdivision (b) of Section 129725, a hospice facility located within the physical plant of another licensed health facility that is under the jurisdiction of the Office of Statewide Health Planning and Development, shall meet the building standards for that category of health facility within which the hospice facility is located, and plans shall be submitted to the office for review of any new construction or renovation of these hospice facilities. As part of the license application, the prospective licensee shall submit evidence of compliance with the building codes enforced by the Office of Statewide Health Planning and Development.

(2) The physical environment of the facility shall be adequate to provide the level of care and service required by the residents of the facility as determined by the department.

(3) In the event the space used by the hospice facility reverts back to the facility with which the hospice facility shared the space, the building standards applicable to the former shared space, as identified by date of enactment of the standards, shall not change due solely to the reversion.

(4) A hospice facility that provides inpatient hospice care and is located within, adjacent to or physically connected to another health facility shall provide all of the following:

(A) A designated nursing station.

(B) Adequate space for the preparation of drugs with lockable, secure storage that is accessible only by authorized personnel.

(C) Signage that shall clearly demarcate the hospice facility area from the facility with which the hospice facility shares space.

(D) Doors for every exit and entrance to the hospice facility.

(E) Contiguous beds within the designated area set aside for the hospice facility.

(f) If a freestanding hospice facility is located on the site of or is physically connected to a health facility that is under the jurisdiction of the Office of Statewide Health Planning and Development or both, the hospice facility shall submit plans for any new construction or renovation of the hospice facility to the office for plan review and approval. The Office of Statewide Health Planning and Development shall review the hospice facility plans to identify any impacts to the health facility under the office's jurisdiction that may compromise the health facility's continued compliance with applicable laws and regulations.

1339.44. (a) A hospice facility shall provide, or make provision for, all of the following services and requirements:

(1) (A) Medical direction and adequate staff. Minimum staffing standards that require at least one registered nurse to be on duty 24 hours per day and a maximum of six patients assigned at any given time per direct caregiver.

(B) For purposes of this section, any additional direct caregiver necessary beyond the registered nurse required pursuant to paragraph (1) may include a registered nurse, as described in Section 2732 of the Business and Professions Code, a licensed vocational nurse, as described in Section 2864 of the Business and Professions Code, and a certified nurse assistant.

(2) Skilled nursing services.

(3) Palliative care.

(4) Social services and counseling services.

(5) Bereavement services.

(6) Volunteer services.

(7) Dietary services.

(8) Pharmaceutical services.

(9) Physical therapy, occupational therapy, and speech-language therapy.

(10) Patient rights.

(11) Disaster preparedness. Disaster preparedness plans for both internal and external disasters shall protect hospice patients, employees, and visitors, and reflect coordination with local agencies that are responsible for disaster preparedness and emergency response.

(12) An adequate, safe, and sanitary physical environment.

(13) Housekeeping services.

(14) Patient medical records.

(15) Other administrative requirements.

(b) The department may adopt regulations that establish standards for the provision of the services in subdivision (a) and any additional qualifications and requirements for licensure above the requirements of this article.

(c) A hospice patient has a right to be informed of his or her rights, and the hospice facility shall protect and promote the exercise of these rights. The hospice facility shall comply with the patients' rights regulation in Section 418.52 of Title 42 of the Code of Federal Regulations unless the

department adopts regulations establishing alternative standards pursuant to Section 1250.1. In addition, the hospice facility shall provide each patient with all of the following:

(1) Information at admission to a hospice facility pursuant to Chapter 3.9 (commencing with Section 1599).

(2) Full information regarding his or her health status and options for end-of-life care.

(3) Care that reflects individual preferences regarding end-of-life care, including the right to refuse any treatment or procedure.

(4) Treatment with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.

(5) Right to visitors of the patient's choosing, at any time the patient chooses, and privacy for those visits.

(d) The hospice facility shall continue to provide services to family and friends after the patient's stay in the hospice facility in accordance with the patient's plan of care. These services may be provided by the hospice services program that operates the hospice facility.

(e) The hospice facility shall demonstrate the ability to meet licensing requirements and shall be fully responsible for meeting all licensing requirements, regardless of whether those requirements are met through direct provision by the facility or under contract with another entity. The hospice facility's reliance on contractors to meet the licensing requirements does not exempt the hospice facility from any requirements or in any way alter the hospice facility's responsibilities. When a health facility provides services under contract to a hospice facility, nothing shall preclude the department from holding the health facility responsible for violations of the law, if the department determines that the facts also constitute a separate violation for the health facility providing services under contract.

(f) The hospice facility shall provide inpatient hospice care in compliance with Section 418.3 and Sections 418.52 to 418.116, inclusive, of Title 42 of the Code of Federal Regulations until the department adopts regulations establishing alternative standards pursuant to Section 1250.1.

SEC. 6. Section 1599 of the Health and Safety Code is amended to read:

1599. It is the intent of the Legislature in enacting this chapter to expressly set forth fundamental human rights which all patients shall be entitled to in a skilled nursing, intermediate care facility, or hospice facility, as defined in Section 1250, and to ensure that patients in such facilities are advised of their fundamental rights and the obligations of the facility.

SEC. 7. Section 1599.1 of the Health and Safety Code is amended to read:

1599.1. Written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Those policies and procedures shall ensure that each patient admitted to the facility has the following rights and is notified of the following facility obligations, in addition to those specified by regulation:

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each patient shall show evidence of good personal hygiene and be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each patient and to encourage self-care and resumption of normal activities. Patients shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and patients. Extension cords to each patient's bed shall be readily accessible to patients at all times.

(g) (1) If a facility has a significant beneficial interest in an ancillary health service provider or if a facility knows that an ancillary health service provider has a significant beneficial interest in the facility, as provided by subdivision (a) of Section 1323, or if the facility has a significant beneficial interest in another facility, as provided by subdivision (c) of Section 1323, the facility shall disclose that interest in writing to the patient, or his or her representative, and advise the patient, or his or her representative, that the patient may choose to have another ancillary health service provider, or facility, as the case may be, provide any supplies or services ordered by a member of the medical staff of the facility.

(2) A facility is not required to make any disclosures required by this subdivision to any patient, or his or her representative, if the patient is enrolled in an organization or entity that provides or arranges for the provision of health care services in exchange for a prepaid capitation payment or premium.

(h) (1) If a resident of a long-term health care facility has been hospitalized in an acute care hospital and asserts his or her rights to readmission pursuant to bed hold provisions, or readmission rights of either state or federal law, and the facility refuses to readmit him or her, the resident may appeal the facility's refusal.

(2) The refusal of the facility as described in this subdivision shall be treated as if it were an involuntary transfer under federal law, and the rights and procedures that apply to appeals of transfers and discharges of nursing facility residents shall apply to the resident's appeal under this subdivision.

(3) If the resident appeals pursuant to this subdivision, and the resident is eligible under the Medi-Cal program, the resident shall remain in the hospital and the hospital may be reimbursed at the administrative day rate, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(4) If the resident appeals pursuant to this subdivision, and the resident is not eligible under the Medi-Cal program, the resident shall remain in the

hospital if other payment is available, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(5) If the resident is not eligible for participation in the Medi-Cal program and has no other source of payment, the hearing and final determination shall be made within 48 hours.

(i) (1) Effective July 1, 2007, Sections 483.10, 483.12, 483.13, and 483.15 of Title 42 of the Code of Federal Regulations in effect on July 1, 2006, shall apply to each skilled nursing facility and intermediate care facility, regardless of a resident's payment source or the Medi-Cal or Medicare certification status of the skilled nursing facility or intermediate care facility in which the resident resides, except that a noncertified facility is not obligated to provide notice of Medicaid or Medicare benefits, covered services, or eligibility procedures.

(2) Effective January 1, 2013, Sections 483.10, 483.12, 483.13, and 483.15 of Title 42 of the Code of Federal Regulations in effect on July 1, 2006, shall apply to each hospice facility, regardless of a resident's payment source or the Medi-Cal or Medicare certification status of the hospice facility in which the resident resides, except that a noncertified facility is not obligated to provide notice of Medicaid or Medicare benefits, covered services, or eligibility procedures and a hospice facility is not obligated to comply with the provisions of subdivision (f) of Section 483.15 of Title 42 of the Code of Federal Regulations.

SEC. 8. Section 1599.4 of the Health and Safety Code is amended to read:

1599.4. In no event shall this chapter be construed or applied in a manner which imposes new or additional obligations or standards on skilled nursing, intermediate care facilities, or hospice facilities or their personnel, other than in regard to the notification and explanation of patient's rights or unreasonable costs.

SEC. 9. Section 1746 of the Health and Safety Code is amended to read:

1746. For the purposes of this chapter, the following definitions apply:

(a) "Bereavement services" means those services available to the surviving family members for a period of at least one year after the death of the patient, including an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to and following the death of the patient.

(b) "Home health aide" has the same meaning as that term is defined in subdivision (c) of Section 1727.

(c) "Home health aide services" means those services described in subdivision (d) of Section 1727 that provide for the personal care of the terminally ill patient and the performance of related tasks in the patient's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient.

(d) "Hospice" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the

last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the following criteria:

(1) Considers the patient and the patient's family, in addition to the patient, as the unit of care.

(2) Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the patient and the patient's family.

(3) Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care that emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services. Limited inpatient services are intended to ensure both continuity of care and appropriateness of services for those patients who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

(4) Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

(5) Provides for bereavement services following death to assist the family in coping with social and emotional needs associated with the death of the patient.

(6) Actively utilizes volunteers in the delivery of hospice services.

(7) To the extent appropriate, based on the medical needs of the patient, provides services in the patient's home or primary place of residence.

(e) "Hospice facility" means a health facility as defined in subdivision (n) of Section 1250.

(f) "Inpatient care arrangements" means arranging for those short inpatient stays that may become necessary to manage acute symptoms or because of the temporary absence, or need for respite, of a capable primary caregiver. The hospice shall arrange for these stays, ensuring both continuity of care and the appropriateness of services.

(g) "An interdisciplinary team" means the hospice care team that includes, but is not limited to, the patient and patient's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver. The team shall be coordinated by a registered nurse and shall be under medical direction. The team shall meet regularly to develop and maintain an appropriate plan of care.

(h) "Medical direction" means those services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the interdisciplinary team, a consultant to the patient's attending physician and surgeon, as requested, with regard to pain and symptom management, and a liaison with physician and surgeons in the community.

(i) "Multiple location" means a location or site from which a hospice makes available basic hospice services within the service area of the parent agency. A multiple location shares administration, supervision, policies and

procedures, and services with the parent agency in a manner that renders it unnecessary for the site to independently meet the licensing requirements.

(j) “Palliative care” means patient and family-centered care that optimizes quality of life of a patient with a terminal illness by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

(k) “Parent agency” means the part of the hospice that is licensed pursuant to this chapter and that develops and maintains administrative control of multiple locations. All services provided from each multiple location and parent agency are the responsibility of the parent agency.

(l) “Plan of care” means a written plan developed by the attending physician and surgeon, the medical director or physician and surgeon designee, and the interdisciplinary team that addresses the needs of a patient and family admitted to the hospice organization. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered.

(m) “Preliminary services” means those services authorized pursuant to subdivision (d) of Section 1749.

(n) “Skilled nursing services” means nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the interdisciplinary team and the patient’s physician and surgeon to a patient and his or her family that pertain to the palliative, supportive services required by patients with a terminal illness. Skilled nursing services include, but are not limited to, patient assessment, evaluation and case management of the medical nursing needs of the patient, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the patient and his or her family, and the instruction of caregivers in providing personal care to the patient. Skilled nursing services shall provide for the continuity of services for the patient and his or her family. Skilled nursing services shall be available on a 24-hour on-call basis.

(o) “Social services/counseling services” means those counseling and spiritual care services that assist the patient and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

(p) “Terminal disease” or “terminal illness” means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

(q) “Volunteer services” means those services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may be used to provide support and companionship to the patient and his or her family during the remaining days of the patient’s life and to the surviving family following the patient’s death.

SEC. 10. Section 1795 of the Health and Safety Code is amended to read:

1795. (a) Notwithstanding any other provision of law, a skilled nursing facility as defined in subdivision (c) of Section 1250, any intermediate care facility, as defined in subdivision (d), (e), (g), and (h) of Section 1250, a congregate living facility, as defined in subdivision (i) of Section 1250, or a hospice facility, as defined in subdivision (n) of Section 1250, shall make reasonable efforts to contact the person named in the resident's admission agreement as the resident's contact person, or the resident's responsible person, within 24 hours after a significant change in the resident's health or mental status.

(b) Notwithstanding any other provision of law, a residential care facility for the elderly, as defined in subdivision (k) of Section 1569.2, shall make reasonable efforts to contact the person named in the resident's admission agreement as the resident's contact person, or the resident's responsible person, within 24 hours after a significant change in the resident's health or mental status.

SEC. 11. Section 128755 of the Health and Safety Code is amended to read:

128755. (a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, hospice facilities, and congregate living facilities, including nursing facilities certified by the department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2) (A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735

shall be filed with the office by electronic media, as determined by the office.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) A hospital shall file the reports required by subdivision (g) of Section 128735 as follows:

(1) For patient discharges on or after January 1, 1999, through December 31, 1999, the reports shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, and shall be available from the office no later than six months after the date that the report was filed.

(2) For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period. The reports shall be filed by electronic tape, diskette, or similar medium as approved by the office. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(3) For patient discharges on or after January 1, 2001, the reports shall be filed by each hospital or its designee for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(d) The reports required by subdivision (a) of Section 128736 shall be filed by each hospital for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(e) The reports required by subdivision (a) of Section 128737 shall be filed by each hospital or freestanding ambulatory surgery clinic for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards

established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(f) Facilities shall not be required to maintain a full-time electronic connection to the office for the purposes of online transmission of reports as specified in subdivisions (c), (d), and (e). The office may grant exemptions to the online transmission of data requirements for limited periods to facilities. An exemption may be granted only to a facility that submits a written request and documents or demonstrates a specific need for an exemption. Exemptions shall be granted for no more than one year at a time, and for no more than a total of five consecutive years.

(g) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date that the report was filed.

(h) The office shall post on its Internet Web site and make available to any person a copy of any report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and, in addition, shall make available in electronic formats reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and subdivisions (a) and (c) of Section 128745, unless the office determines that an individual patient's rights of confidentiality would be violated. The office shall make the reports available at cost.

SEC. 12. Section 129725 of the Health and Safety Code is amended to read:

129725. (a) (1) "Hospital building" includes any building not specified in subdivision (b) that is used, or designed to be used, for a health facility of a type required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(2) Except as provided in paragraph (7) of subdivision (b), hospital building includes a correctional treatment center, as defined in subdivision (j) of Section 1250, the construction of which was completed on or after March 7, 1973.

(b) "Hospital building" does not include any of the following:

(1) Any building where outpatient clinical services of a health facility licensed pursuant to Section 1250 are provided that is separated from a building in which hospital services are provided. If any one or more outpatient clinical services in the building provides services to inpatients, the building shall not be included as a "hospital building" if those services provided to inpatients represent no more than 25 percent of the total outpatient services provided at the building. Hospitals shall maintain on an ongoing basis, data on the patients receiving services in these buildings, including the number of patients seen, categorized by their inpatient or

outpatient status. Hospitals shall submit this data annually to the State Department of Health Services.

(2) Any building used, or designed to be used, for a skilled nursing facility or intermediate care facility if the building is of single-story, wood-frame or light steel frame construction.

(3) Any building of single-story, wood-frame or light steel frame construction where only skilled nursing or intermediate care services are provided if the building is separated from a building housing other patients of the health facility receiving higher levels of care.

(4) Any freestanding structures of a chemical dependency recovery hospital exempted under subdivision (c) of Section 1275.2.

(5) Any building licensed to be used as an intermediate care facility/developmentally disabled habilitative with six beds or less and any intermediate care facility/developmentally disabled habilitative of 7 to 15 beds that is a single-story, wood-frame or light steel frame building.

(6) Any building subject to licensure as a correctional treatment center, as defined in subdivision (j) of Section 1250, the construction of which was completed prior to March 7, 1973.

(7) (A) Any building that meets the definition of a correctional treatment center, pursuant to subdivision (j) of Section 1250, for which the final design documents were completed or the construction of which was begun prior to January 1, 1994, operated by or to be operated by the Department of Corrections, the Department of the Youth Authority, or by a law enforcement agency of a city, county, or a city and county.

(B) In the case of reconstruction, alteration, or addition to, the facilities identified in this paragraph, and paragraph (6) or any other building subject to licensure as a general acute care hospital, acute psychiatric hospital, correctional treatment center, or nursing facility, as defined in subdivisions (a), (b), (j), and (k) of Section 1250, operated or to be operated by the Department of Corrections, the Department of the Youth Authority, or by a law enforcement agency of a city, county, or city and county, only the reconstruction, alteration, or addition, itself, and not the building as a whole, nor any other aspect thereof, shall be required to comply with this chapter or the regulations adopted pursuant thereto.

(8) Any freestanding building used, or designed to be used, as a congregate living health facility, as defined in subdivision (i) of Section 1250.

(9) Any freestanding building used, or designed to be used, as a hospice facility, as defined in subdivision (n) of Section 1250.

SEC. 13. Section 2.5 of this bill incorporates amendments to Section 1250 of the Health and Safety Code proposed by both this bill and Senate Bill 1228. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2013, (2) each bill amends Section 1250 of the Health and Safety Code, and (3) this bill is enacted after Senate Bill 1228, in which case Section 2 of this bill shall not become operative.

SEC. 14. Section 4.5 of this bill incorporates amendments to Section 1266 of the Health and Safety Code proposed by both this bill and Assembly

Bill 1710. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2013, (2) each bill amends Section 1266 of the Health and Safety Code, and (3) this bill is enacted after Assembly Bill 1710, in which case Section 4 of this bill shall not become operative.

SEC. 15. No reimbursement is required by this act pursuant to Section 6 of Article XIII B 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.