AMENDED IN SENATE JULY 15, 2010

AMENDED IN SENATE JUNE 3, 2010

AMENDED IN SENATE MARCH 25, 2010

AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 22, 2009

AMENDED IN ASSEMBLY APRIL 14, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 950

Introduced by Assembly Member Hernandez

February 26, 2009

An act to amend Sections 1250, 1250.1, 1266, 1746, and 128755 of, and to add Sections 1749.1 and 1749.3 to, the Health and Safety Code, relating to hospice care.

LEGISLATIVE COUNSEL'S DIGEST

AB 950, as amended, Hernandez. Hospice providers: licensed 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 ~~license and regulate~~ *develop*

regulations governing licensure of, hospice facilities, as defined. It would impose various requirements on these facilities.

~~This bill would also permit the department to use specified federal regulations as the basis for hospice facility licensure until the department promulgates regulations.~~

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

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. 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 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 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 state 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 that 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 state 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 facility licensed by the department and operated by a licensed and certified provider of hospice services. Hospice services include, but are not limited to, routine care, continuous care, inpatient respite care, general patient care, and the hospice facility services described in Section 1749.3.

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

1250.1. (a) The state 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 Mental Health 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 state 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 state 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 state 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	$ 600.00	per facility
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 facility
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 subdivisions (c) and (d).

(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 that year. Thereafter, the licensure fee for hospice facilities shall be established pursuant to subdivisions (c) and (d).

(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) No fees shall 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. No fees shall 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, no fee shall 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 cash flow 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. 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 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” refers to medical treatment, interdisciplinary care, or consultation provided to the patient or family members, or both, that have as its primary purposes preventing or relieving suffering and enhancing the quality of life, rather than curing the disease, as described in subdivision (b) of Section 1339.31, of a patient who has an end-stage medical condition.

(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 by the multiple locations 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 program. 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. 6. Section 1749.1 is added to the Health and Safety Code, to read:

~~1749.1. (a) (1) Only a hospice licensed and certified in California may apply for a hospice facility license.~~

~~(2) On or after the effective date of regulations to implement this section, a hospice provider that seeks to provide short-term inpatient respite or inpatient care directly in the hospice provider's own facility shall submit an application for licensure as a hospice facility.~~

~~(3) A hospice provider that provides short-term inpatient respite or inpatient care directly in the hospice provider's own facility prior to the effective date of regulations to implement this section may also continue to be licensed as a specialty hospital, skilled nursing facility, or congregate living health facility.~~

~~(4) Each application for a new or renewed hospice facility license under this chapter shall be accompanied by an annual Licensing and Certification Program fee set in accordance with Section 1266.~~

~~(5) A hospice facility shall be separately licensed, irrespective of the location of the facility.~~

~~(b) Hospice facility licensees shall be responsible for obtaining criminal background checks for employees, volunteers, and contractors in accordance with federal Medicare conditions of participation (42 C.F.R. 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.~~

~~(c) Building standards adopted pursuant to this section relating to fire and panic safety, and other regulations adopted pursuant to this section, 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 adopted pursuant to this section.~~

~~(d) The hospice facility shall meet the fire protection standards set forth in federal Medicare conditions of participation (42 C.F.R. 418 et seq.). A hospice facility shall meet the same building standards as a congregate living health facility as described in subparagraph (B) of paragraph (2) of subdivision (i) of Section 1250.~~

~~(e) A hospice facility shall operate as a freestanding health facility, but may also be located adjacent to, physically connected~~

~~to, or on the building grounds of, another health facility or residential care facility. A hospice facility shall not be required to submit construction plans to the Office of Statewide Health Planning and Development for new construction or renovation. As part of the application for licensure, the prospective licensee shall submit evidence of compliance with local building codes. In addition, 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.~~

1749.1. The department shall develop regulations governing hospice facility licensure by June 30, 2015. The regulations shall include, but not be limited to, the following requirements:

(a) A hospice facility, at a minimum, shall meet the same staffing standards applicable to a congregate living health facility, as defined in Section 1250.

(b) A hospice facility with more than 19 beds or that is a multistory building shall meet building review and seismic safety standards applicable to a hospital building, pursuant to Chapter 1 (commencing with Section 129675) of Part 7 of Division 107.

SEC. 7. Section 1749.3 is added to the Health and Safety Code, to read:

1749.3. (a) In order for a hospice program to be licensed as a hospice facility, it shall provide, or make provision for, all of the following services and requirements:

(1) Medical direction and adequate staff.

(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.

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

(13) Housekeeping services.

(14) Patient medical records.

(15) Other administrative requirements.

(b) The department shall adopt regulations that establish standards for the provision of the services in subdivision (a). These regulations shall include, but are not limited to, all of the following:

~~(1) Minimum staffing standards that require at least one licensed nurse to be on duty 24 hours per day and a maximum of six patients at any given time per direct care staff person.~~

(1) Minimum staffing standards that ensure that a hospice facility, at a minimum, meets the same staffing standards applicable to a congregate living health facility, as defined in Section 1250.

(2) Patient rights provisions that provide each patient with all of the following:

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

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

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

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

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

(4) Additional qualifications and requirements for licensure above the requirements of this section and Section 1749.1.

(c) The hospice facility shall provide a homelike environment that is comfortable and accommodating to both the patient and the patient's visitors.

(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 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 or in any way mitigate the hospice facility's responsibilities.

SEC. 8. 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 state 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 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. 9. Until the department promulgates regulations, the department may use the federal Centers for Medicare and Medicaid Services, Department of Health and Human Services Hospice Care regulations as contained in Sections 418.3 and 418.52 to 418.116, inclusive, of Title 42 of the Code of Federal Regulation, as those~~

~~provisions read on December 31, 2010, as the basis for hospice facility licensure.~~

~~SEC. 10.~~

SEC. 9. 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.

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