S276545

IN THE SUPREME COURT
OF THE
STATE OF CALIFORNIA

CHARLES LOGAN

Plaintiff and Respondent,

vs.

COUNTRY OAKS PARTNERS, LLC, et al.

Defendants and Appellants.

On Review from the Court of Appeal for the Second Appellate District,
Division Four, Case No. B312967

After an Appeal from the Superior Court for the State of California,
(Los Angeles County Super. Ct. No. 20STCV26536)

REQUEST FOR JUDICIAL NOTICE BY [PROPOSED] *AMICUS CURIAE* CALIFORNIA ASSOCIATION OF HEALTH FACILITIES IN SUPPORT OF DEFENDANTS-APPELLANTS; DECLARATION OF MARK E. REAGAN; [PROPOSED] ORDER

HOOPER, LUNDY & BOOKMAN, P.C.

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Proposed *amicus curiae* California Association of Health Facilities ("CAHF") respectfully requests that this Court take judicial notice of certain excerpts from the rulemaking files for California Code of Regulations, title 22, sections 72516 and 73518 (collectively, "Section 72516") pursuant to Evidence Code sections 452, subdivision (a) [the decisional, constitutional, and statutory law of California], (b) [regulations issued by a public entity], (c) [official acts of the executive department of any state in the United States], and (h) [facts and propositions that are not reasonably subject to dispute and capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy]. Only the most relevant excerpts from the rulemaking are included in the request for judicial notice. Specifically, CAHF requests judicial notice of the following:

1. Table of Contents for CD and Hard Copies of Rulemaking File and Navigation Guide, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01, Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities (June 8, 2006), attached hereto and incorporated herein as **Exhibit 1**.

2. Excerpts from the Initial Statement of Reasons, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 16, 2004), attached hereto and incorporated herein as **Exhibit 2**.

3. Excerpts from Addendum II – Summaries and Response to the

Comments Received During the Public Comment Period, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 25, 2005), attached hereto and incorporated herein as **Exhibit 3**.

4. Excerpts from the Final Statement of Reasons, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 29, 2005), attached hereto and incorporated herein as **Exhibit 4**.

Exhibits 1, 2, 3, and 4 are true and correct copies of the rulemaking for Section 72516. (See Declaration of Mark E. Reagan in Support of Request For Judicial Notice by Proposed *Amicus curiae* California Association Of Health Facilities in Support Of Defendants-Appellants, ¶¶ 3-7 ("Reagan Decl.").) California Department of Health Services[1] lodged a copy of this rulemaking record as part of the administrative record for the case *Parkside Special Care Center, Inc., et al v. Shewry, et al.* (Super. Ct. San Diego County, 2006, No. GIC860574) ("*Parkside*"), in which CAHF was a plaintiff. (*Id.*, at ¶¶ 2-3.) CAHF is not aware that these exhibits were presented to the trial court. CAHF was not an *amicus curiae* or party before the trial court or the Court of Appeal and therefore could not have provided this material to either of those forums.

As an initial point, the California Supreme Court may take judicial

[1] The California Department of Public Health ("CDPH") was formerly known as the California Department of Health Services, which was reorganized into the CDPH and the Department of Health Care Services.

notice of documents submitted by *amicus curiae.* (See, e.g., *Ste. Marie v. Riverside County Regional Park & Open-Space Dist.* (2009) 46 Cal.4th 282, 293 fn. 7 [judicially noticing executive documents filed by a public entity such as master plans, board resolutions, and declarations of policy]; *East Bay Asian Local Development Corp. v. State of California* (2000) 24 Cal.4th 693, 711 fn. 5 [granting judicial notice of letters submitted by an *amicus curiae* encouraging the passage of a California Assembly Bill]; *Cortez v. Purolator Air Filtration Products Co.* (2000) 23 Cal.4th 163, 168 fn. 2 [granting judicial notice of a previous brief filed by an *amicus curiae*]; *Schifando v. City of Los Angeles* (2003) 31 Cal.4th 1074, 1089 fn. 4, *as modified (Dec. 23, 2003)* [granting judicial notice of a Ninth Circuit decision for *amicus curiae*]; *People ex rel. Dept. of Conservation v. El Dorado County* (2005) 36 Cal.4th 971, 981 fn. 5. [granting judicial notice for several *amici curiae*].)

Exhibits 1, 2, 3, and 4 are appropriate for judicial notice because they are official acts of the California Department of Health Services and highly relevant to this case. Evidence Code section 452, subdivision (a) permits the Court to take judicial notice of the "statutory law of any state of the United States." (Evid. Code, § 452, subd. (a).) Evidence Code section 452, subdivision (b) allows judicial notice to be taken of "[r]egulations … issued by … any public entity in the United States." (Evid. Code, § 452, subd. (b).) Similarly, Evidence Code section 452, subdivision (c) allows a

court to judicially notice the official acts of the executive department of California. Here, **Exhibits 1, 2, 3, and 4** are proper for judicial notice because they are part of the rulemaking for California Code of Regulations, title 22, sections 72516 and 73518, making them official acts of the California Department of Health Services. (Evid. Code, § 452, subd. (c).) A long line of cases demonstrate that courts can judicially notice rulemaking history, including initial statements of reasons, notices of proposed rulemaking, and proposed amendments to rules under Evidence Code section 452, subdivisions (a), (b), and (c). (See, e.g., *West Coast University, Inc. v. Board of Registered Nursing* (2022) 82 Cal.App.5th 624, 642 fn. 5 [granting judicial notice of "notice of proposed rulemaking, initial statement of reasons for the rulemaking, and proposed language for the rulemaking" pursuant to Evidence Code section 452, subd. (a) and (c)]; *Department of Industrial Relations v. Occupational Safety & Health Appeals Bd.* (2018) 26 Cal.App.5th 93, 108 fn. 7 [granting judicial notice of previous and current versions of regulations under Evidence Code section 452, subd, (a) and (b)]; *As You Sow v. Conbraco Industries* (2005) 135 Cal.App.4th 431, 439 fns. 3-4 [judicially noticing a notice of proposed rulemaking, initial statement of reasons, and proposed amendments to a regulation as official acts of California under Evidence Code section 452, subd. (a) and (c)].)

Moreover, these exhibits are highly relevant to this case because

they prove that several documents clearly regarding health care decisions—such as pharmacy selection and facility policies—may also be separate from the Standard Admissions Agreement ("SAA"). Courts may turn to the rulemaking history of a regulation when the plain language of the regulation is ambiguous. (See *Department of Industrial Relations v. Occupational Safety & Health Appeals Bd., supra,* 26 Cal.App.5th 93, 101.) Such evidence disproves Plaintiff's and the Court of Appeal's "decoupling" theory. (See Answer Brief at p. 23; *Logan v. Country Oaks Partners, LLC* (2022) 82 Cal.App.5th 365, 373.) Therefore, **Exhibits 1, 2, 3, and 4** are appropriate for judicial notice pursuant to Evidence Code section 452, subdivisions (a), (b), and (c).

Finally, under Evidence Code section 452, subdivision (h), **Exhibits 1, 2, 3, and 4** are appropriate for judicial notice because they are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy. Significantly, these exhibits exist as part of the official rulemaking record for 22 CCR 72516 and 73518. As a result, **Exhibits 1, 2, 3, and 4** are further noticeable under Evidence Code section 452, subdivision (h).

For these reasons, CAHF respectfully requests the California Supreme Court grant judicial notice of **Exhibits 1, 2, 3, and 4**.

DATED: May 31, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: _____

MARK E. REAGAN
JEFFREY LIN
Attorneys for *Amicus curiae* California Association of Health Facilities

CERTIFICATE OF COMPLIANCE PURSUANT TO CALIFORNIA RULES OF COURT RULE 8.504(d)(1)

Pursuant to California Rules of Court Rule 8.504(d)(1), I certify that according to Microsoft Word the attached brief is proportionally spaced, has a typeface of 13 points and contains 1163 words.

DATED: May 31, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: _____

MARK E. REAGAN
JEFFREY LIN
Attorneys for *Amicus curiae* California Association of Health Facilities

7329052.4

Exhibit 1

State of California—Health and Human Service Agency

Department of Health Services

California
Department of
Health Services

ARNOLD SCHWARZENEGGER
Governor

June 9, 2006

TO WHOM IT MAY CONCERN:

The Department is hereby submitting a copy, via CD and hardcopy, of the file of the rulemaking record (R-05-01, Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities) for Title 22, California Code of Regulations, adopting Sections 72516 and 73518. I certify that the documents provided, via enclosed disk and hardcopies, constitute a complete representation of the rulemaking record.

Sincerely,

Charles E. Smith, Chief
Office of Regulations

Enclosures

June 8, 2006

RULEMAKING FILE FOR R-05-01: Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities.

Table of Contents for CD and Hard Copies of Rulemaking File and Navigation Guide

Subject	Bates Numbers
a. 916 letters during the public comment period.	
Issue No. 1	000434-000508
Issue No. 2	000509-000608
	Volume 5
Issue No. 3	000609-000750
Issue No. 4	000751-000816
	Volume 6
Issue No. 5	000817-000904
Issue No. 6	000905-000984
Issue No. 7	000985-001062
	Volume 7
Issue No. 8	001063-001161
Issue No. 10 (Note: Out of sequence)	001162-001195
Issue No. 9	001196-001258
	Volume 8
Issue No. 11	001259-001339
Issue No. 12	001340-001427
Issue No. 13	001428-001475
	Volume 9
Issue No. 14	001476-001525
Issue No. 15	001526-001550
Issue No. 16	001551-001587
Issue No. 17	001588-001616
Issue No. 18	001617-001648
Issue No. 19	001649-001685
	Volume 10
Issue No. 20	001686-001722
Issue No. 21	001723-001759
Issue No. 22	001760-001792
Issue No. 23	001793-001839
Issue No. 24	001840-001869
	Volume 11
Issue No. 25	001870-001893
Unique Letters	001895-002089
	Volume 12
b. 308 letters received after the close of public comment.	002090-002300
	Volume 13
	002301-002557
	Volume 14
9. Two copies of the post-hearing change public availability	002558-002732

Subject	Bates Numbers
mailing to include the proposed regulations with post-hearing changes indicated and notice dated March 8, 2005. (Note: Postmark is not visible on the copy of envelope.) Please note in the photo-copying of the first packet, in revised Attachment A--Resident's Rights page 3 is omitted (resulting in the absence of page 3) and page 5 is copied twice (resulting in identical pages at 002598 and 002599). For hard copy review of the rulemaking file, a copy in yellow of the omitted page is added and numbered 002596-y. The copy of the second packet displays the revised Attachment A--Resident's Rights page 3 at 002683. For CD review of the rulemaking file, a hard copy of page 3 is attached. Both packets are complete in the original rulemaking file.	002560
10. Correspondence received during the 15-day post-hearing change availability.	**Volume 14** 002733-002793
11. Post Public Participation Documents: a. Updated Informative Digest b. Final Statement of Reasons -- Modified July 6, 2005 -- As initially certified on May 18, 2005 1. Statements of Determinations 2. Addendum I – List of Commenters for the Public Notice. 3. Addendum II – Summaries and Response to the Comments Received During the Public Comment Period. -- Modified July 6, 2005 -- As initially certified on May 18, 2005 4. Addendum III – List of commenters for the Post-Hearing Change 15-Day Availability. 5. Addendum IV – Summaries and Response to the Comments Received During the Post-Hearing Change Availability.	**Volume 15** 002794-003104 002795-002796 002797-002835 002836-002874 002875 002876-002978 **Volume 16** 002979-003032 003033-003086 003087 003088-003104
12. Delegation Orders a. Richard Bayquen b. Richard Joseph Jackson, M.D., M.P.H.	**Volume 17** 003105-003109

Subject	Bates Numbers
	Volume 17
13. Memo to OAL dated July 6, 2005, and Replacement Pages to the Rulemaking Record File.	003110-003141
a. Standard Admission Agreement	
1. pages 7 and 8	003113-003114
2. page 12	003115
b. Standard Admission Agreement, Attachment E.	003116-003117
c. Final Statement of Reasons	
1. pages 22 through 26	003118-003122
2. pages 32 and 33	003123-003124
d. Addendum II	
1. page 21	003126
2. page 27 through 31	003127-003131
3. page 37	003125 (note: out of sequence)
Non-substantive Changes	003132-003141
	Volume 17
14. Certifications	003142-003144
	Volume 17
Miscellaneous Documents in the Archive File	003145-003152

Exhibit 2

Tab IV

Public Notice
Initial Statement of Reasons
Proposed Regulations

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

ACTION: Notice of Proposed Rulemaking
Title 22, California Code of Regulations

SUBJECT: California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, **R-05-01**

PUBLIC PROCEEDINGS: Notice is hereby given that the California Department of Health Services will conduct a public hearing commencing at 10 a.m. on July 14, 2004 in the Auditorium, 1500 Capitol Avenue, Sacramento, CA, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions relevant to the action described in this notice.

Please Note: Attendees are required to register at the security desk when entering the building.

Any written statements, arguments or contentions must be received by the Office of Regulations, Department of Health Services, MS 0015, P.O. Box 997413, Sacramento, CA 95899-7413, by 5 p.m. on July 14, 2004 , which is hereby designated as the close of the written comment period. It is requested but not required that written statements, arguments or contentions sent by mail or hand-delivered be submitted in triplicate.

Comments by FAX (916-440-7714) or email (regulation@dhs.ca.gov) must be received before 5 p.m. on the last day of the public comment period. All comments, including email or fax transmissions, should include the author's name and U.S. Postal Service mailing address in order for the Department to provide copies of any notices for proposed changes in the regulation text on which additional comments may be solicited.

CONTACTS: **In any of the following inquiries, please identify the action by using the Department regulation control number, R-05-01:**

1. In order to request a copy of this regulation package be sent to you, please call (916) 440-7695 or email regulation@dhs.ca.gov.

2. Inquiries regarding the substance of the proposed regulations described in this notice may be directed to Paula Campbell of Licensing and Certification Division at (916) 552-8756.

3. All other inquiries concerning the action described in this notice may be directed to Barbara S. Gallaway, RN, MSN, of the Office of Regulations at (916) 440-7689, or to the designated backup contact person, Linda Tutor, at (916) 440-7695.

Persons wishing to use the California Relay Service may do so at no cost. The telephone numbers for accessing this service are: 1-800-735-2929, if you have a TDD; or 1-800-735-2922, if you do not have a TDD.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:

Section 1599.61 of the Health and Safety Code requires the Department to develop, and skilled nursing and intermediate care facilities to use, a standard admission agreement which complies with all applicable state and federal laws.

The Department proposes to add Section 72516 to Title 22 of the California Code of Regulations to implement this requirement for skilled nursing facilities (as defined in Section 72103), and Section 73518 to implement this requirement for intermediate care facilities (as defined in Section 73051).

The proposed regulations require these facilities to use the "California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities", form number HS 327 (04/04), which is incorporated by reference. The Standard Admission Agreement contains the following sections: Preamble, Identification of Parties to this Agreement, Consent to Treatment, Your Rights as a Resident, Financial Arrangements, Transfers and Discharges, Bed Holds and Readmission, Personal Property Protection, Photographs, Confidentiality of Your Medical Information, Facility Rules and Grievance Procedure, and Other Provisions of this Agreement.

The Standard Admission Agreement also contains attachments needed to meet all statutory requirements. Those attachments include: (A) Resident's Bill of Rights, (B-1) Supplies and Services Included in the Basic Daily Rate for Private Pay and Privately Insured Residents, (B-2) Optional Supplies and Services Not Included in Basic Daily Rate for Private Pay and Privately Insured Residents, (C-1) Supplies and Services Included in the Basic Daily Rate for Medi-Cal Residents, (C-2) Supplies and Services Not Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately, (C-3) Optional Supplies and Services Not Covered by Medi-Cal That May Be Purchased By Medi-Cal Residents, (D-1) Supplies and Services Covered by the Medicare Program For Medicare Residents, (D-2) Optional Supplies and Services Not Covered by Medicare That May Be Purchased By Medicare Residents, and (E) Authorization for Disclosure of Medical Information.

The proposed regulations provide that the Standard Admission Agreement is the only document a patient must sign at the time of, or as a condition of, admission to the facility, or as a condition of continued stay in the facility.

The proposed regulations prohibit any alteration of the Standard Admission Agreement without prior written authorization from the Department, except to fill in spaces provided on the form to record information specific to the facility or the resident.

The proposed regulations further provide that arbitration agreements (also referred to in statute as "arbitration clauses") shall not be presented to prospective residents as part of the Standard Admission Agreement. The proposed regulations also require that arbitration agreements must contain an advisory, prominently printed in bold 12 point font, indicating that residents cannot be required to sign an arbitration agreement as a condition of admission to the facility, nor can patients waive their right to sue for violations of the Resident Bill of Rights.

While federal law and regulation establish certain resident rights and require the provision of certain information before, or at the time of admission, there are no federal requirements for use of a standard admission agreement or federal standards with regard to the content of admission agreements for skilled nursing or intermediate care facilities. On the other hand, the content of the proposed Standard Admission Agreement must be consistent with federally established resident rights and facility responsibilities. There are no other state regulations specific to the content of admission agreements. The only statutory requirements with respect to a standard admission agreement and the content thereof are found in Health and Safety Code Sections 1599.60 through 1599.89, and 123222.1.

AUTHORITY: Section 1275, Health and Safety Code.

REFERENCE: Sections 1276, 1430, 1599.60, 1599.61, 1599.81, 123222.1, Health and Safety Code.

FISCAL IMPACT ESTIMATE:

A. Fiscal Effect on Local Government: $0

B. Fiscal Effect on State Government: $0

C. Fiscal Effect on Federal Funding of State Programs: $0

D. The Department is not aware of any cost impacts that a representative private person would necessarily incur in reasonable compliance with the proposed action.

While there may be some cost impact on skilled nursing or intermediate care facilities that must comply with these regulations, any impact on these businesses is a result of the legislation directing the Department to adopt and facilities to use a standard admission agreement, not these regulations themselves. However, the Department expects minor savings to these businesses, since they will not have to incur costs associated developing, maintaining, and defending their own contracts of admission.

E. Other Nondiscretionary Cost or Savings Imposed on Local Agencies: $0

DETERMINATIONS: The Department has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

The Department has made an initial determination that the regulations would not have a significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

The Department has determined that the regulations would not affect small business because any impact on these businesses is a result of the legislation (Health and Safety Code Section 1599.61) directing the Department to adopt and facilities to use a standard admission agreement.

The Department has determined that the regulations will have no impact on housing costs.

AVAILABILITY OF STATEMENT OF REASONS AND TEXT OF REGULATIONS: The Department has prepared and has available for public review an initial statement of reasons for the proposed regulations, all the information upon which the proposed regulations are based, and the text of the proposed regulations. A copy of the initial statement of reasons and a copy of the text of the proposed regulations are available upon request by writing to the Office of Regulations at the address noted above, which address will also be the location of public records, including reports, documentation, and other material related to the proposed regulations (rulemaking file). Additionally, a copy of the final statement of reasons (when prepared) will be available upon request from the Office of Regulations at the address noted above. Materials regarding the proposed regulations that are available via the Internet may be accessed at http://www.dhs.ca.gov/regulation/.

AVAILABILITY OF CHANGED OR MODIFIED TEXT: The full text of any regulation which is changed or modified from the express terms of the proposed action will be

made available by the Department's Office of Regulations at least 15 days prior to the date on which the Department adopts, amends, or repeals the resulting regulation.

ADDITIONAL STATEMENTS AND COMMENTS: In accordance with Government Code Section 11346.5(a)(13) the Department must determine that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action.

Other regulation changes may be scheduled for hearing at the same time appointed for public hearing on the action described in this notice. An agenda for the public hearing will be posted at the time and place of hearing designated above.

Sign language interpreting services at a public hearing or other reasonable accommodation will be provided upon request. Such request should be made no later than 21 days prior to the close of the written comment period, and addressed to the Office of Civil Rights within the Department of Health Services by phone (916-440-7370); FAX (916-440-7395); TDD (916-440-7399); or email (civilrights-ra@dhs.ca.gov).

DEPARTMENT OF HEALTH SERVICES

R-05-01

Dated: April 23, 2004

Sandra Shewry
Director

INITIAL STATEMENT OF REASONS

Chapter 631, Statutes of 1997, added Section 1599.61 to the Health and Safety Code (HSC) requiring all skilled nursing and intermediate care facilities to use a standard admission agreement developed by the Department of Health Services and requiring the Department to develop a comprehensive Patient's Bill of Rights. This legislation, authored by Senator Vasconcellos, expressed the following findings and declarations of the Legislature:

- Many nursing home admission agreements are unnecessarily long, complicated, and incomprehensible to consumers;
- It is in the best interests of nursing home residents that admission agreements meet standards required under state and federal law and that they not violate residents' rights;
- There is little uniformity among admission agreements and it is an unnecessary burden and expense to review all agreements for compliance with state and federal law; and,
- A uniform nursing home admission agreement would provide consistency, promote and protect residents' rights, and conserve state resources and funds.

The bill expressed the specific intent of the Legislature to mandate a standard admission agreement to be used for all admissions to all skilled nursing facilities, intermediate care facilities, and nursing facilities in California.

Two points of terminology need clarification. First, the legislation refers to skilled nursing facilities, intermediate care facilities, and nursing facilities. Under California law, only "skilled nursing facilities" and "intermediate care facilities" are licensed facility types. "Nursing facilities" is a term defined in Section 1250 (k) of the Health and Safety Code to mean a licensed skilled nursing facility or licensed intermediate care facility that is certified for participation in the federal Medicare Program and/or Medicaid Program (called Medi-Cal in California). Accordingly, since "nursing facilities" are "skilled nursing facilities" or "intermediate care facilities", regulatory action is only required to implement this legislation with regard to skilled nursing facilities and intermediate care facilities. A separate regulation for "nursing facilities" is not required.

Second, there has been an evolution in the term used to identify persons receiving care in skilled nursing or intermediate care facilities. Some provisions of law and regulation refer to these persons as "patients" and some refer to the same persons as "residents". In fact, the legislation requiring adoption of a standard admission agreement uses both these terms interchangeably. Throughout this document and in the proposed regulations, the term "resident" is used to refer to persons receiving care

in skilled nursing or intermediate care facilities, because that term is currently more commonly used.

The Department proposes to add Sections 72516 and 73518 to Title 22 of the California Code of Regulations to implement the provisions of Section 1599.61 of the Health and Safety Code. The text of the two regulations is identical: Section 72516 applies these requirements to skilled nursing facilities and Section 73518 applies them to intermediate care facilities. "Skilled nursing facilities" which must use the Standard Admission Agreement are defined in Section 72103 of Title 22 of the California Administrative Code and include both freestanding facilities and facilities which operate as a distinct part of a general acute care hospital. Section 73051 of Title 22 defines "intermediate care facilities" which must use the Standard Admission Agreement including both freestanding facilities and those that operate as a distinct part of a general acute care hospital. The specific purpose and rationale for each subsection of the proposed regulations is as follows:

Subsection (a): This subsection requires the licensee to use the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, DHS Form Number HS 327 (04/04), which is incorporated by reference. The Department has determined that it will be more efficient and effective to incorporate the standard form by reference, rather than adopting regulations that specify format standards and specific language and requiring each facility to create its own form consistent with those standards. By adopting regulations that incorporate the form by reference, the Department can make available – in hard copy, in electronic format, and on the Internet – the specific form required for use by licensees. This is also consistent with the goals of the statutory mandate to promote uniformity of admission agreements, assure compliance with all state and federal requirements, and minimize associated administrative burden.

A discussion of the specific content of the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities follows this discussion of the text of the proposed regulations.

Subsection (b): This subsection prohibits any alteration of the standard admission agreement by the licensee without prior written approval from the Department, except that information specific to the facility or the resident may be entered in spaces provided in the standard admission agreement form. HSC Section 1599.61 (b) (1) contains the prohibition that "No facility shall alter the standard agreement unless so directed by the department", in order to ensure that the admission agreement is not arbitrarily altered by the licensee and that only the standard agreement adopted by the Department is used. On the other hand, HSC 1276 (b) requires "regulations shall permit program flexibility ... as long as statutory requirements are met and the use has the prior written approval of the department". This provides the opportunity for a licensee to request, and the Department to approve, facility-specific program flexibility

in the standard agreement in order to meet unique circumstances as long as all statutory requirements are met.

Though not specifically addressed by statute, allowing the entry of information specific to a facility and a resident is essential from a practical perspective. The California Standard Admission Agreement must offer the flexibility to identify the specific parties to the contract and to accommodate legitimate differences among facilities, such as available optional services and related prices.

Subsection (c): This subsection provides that no resident or their representative can be required to sign any other document at the time of, or as a condition of, admission to the facility, or as a condition of continued stay in the facility. This is consistent with HSC Section 1599.60 (b) which defines a contract of admission as including all documents which must be signed by the resident or his or her representative at the time of, or as a condition of, admission. This protects residents against the possibility that documents other than the standard admission agreement might be represented to them as documents, which require their signature as a condition of admission. On the other hand, this provision does not preclude facilities from discussing other documents (such as selection of a pharmacy), and presenting those documents to prospective residents for their voluntary signature, as long as those documents are clearly separate from the admission agreement and are not presented as a condition of admission.

While HSC Section 1599.60 (b) does not specifically provide that the admission agreement is the only document which must be signed "as a condition of continued stay in the facility", the Department proposes to include this language to prevent potential confusion and possible misrepresentation of documents to residents for signature after their admission. Inclusion of this phrase is simply a clarifying statement of fact. Failure to sign any specific document after admission is not included in state or federal law or regulation, or in the proposed California Standard Admission Agreement (Section VI. Transfers and Discharges), as a legitimate reason for involuntary discharge from a facility. Since failure to sign any document after admission is not a legitimate reason for involuntary discharge, then no document other than the standard admission agreement must be signed as a condition of continued stay in the facility.

Subsection (d): This subsection prohibits the inclusion of an arbitration agreement as part of the California Standard Admission Agreement. This provision is based on the following interpretation of the Health and Safety Code:

- Section 1599.60 defines "contract of admission" to include "all documents which a resident or his or her representative must sign at the time of, or as a condition of, admission to a long-term health care facility";

- While Section 1599.81 (a) and (d) allow an arbitration clause to be included in a contract of admission, no provision of law requires inclusion of an arbitration clause therein nor does any provision of law require that an arbitration agreement be signed at the time of admission;
- Section 1599.81 (a) mandates that "All contracts of admission that contain an arbitration clause shall clearly indicate that agreement to arbitration is not a precondition for medical treatment or for admission to the facility";
- Section 1599.81 (b) provides that "all arbitration clauses shall be included on a form separate from the rest of the admission contract."

Accordingly, an arbitration agreement: 1) need not be signed as a condition of admission; 2) if present, must be separate from the contract of admission; and 3) is not otherwise mandated by statute to be included within the standard admission agreement. Therefore, an arbitration agreement cannot be presented to prospective residents as though it were part of the standard admission agreement. This proposed subsection does not prohibit the use of arbitration agreements; rather, it requires that any arbitration agreement be separate from the standard admission agreement.

Subsection (d) also requires that any arbitration agreement must contain a prominently placed advisory in bold-face font of not less than 12 point type, as follows: "**Residents are not required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights.**" This provision implements the intent of HSC Section 1599.81 (a) that patients be clearly notified that agreement to arbitration is not a precondition for admission, and HSC Section 1599.81 (d) requiring notice to patients that they may not waive the ability to sue for violation of the Patient's Bill of Rights. Section 123222.1 of the Health and Safety Code requires that admission papers and forms, as well as certain other documents, used by skilled nursing and intermediate care facilities must be printed in at least 12 point type that is clear and legible.

During the course of developing this regulation package, the Department received a petition requesting the adoption of regulations to implement the standard admission agreement requirements of Section 1599.61 of the Health and Safety Code. The Department's response to the petition was published in the California Regulatory Notice Register on January 28, 2000. The petition and DHS response are in the rulemaking file for this proposed regulatory action.

California Standard Admission Agreement:

Since the enactment of Health and Safety Code Section 1599.61, the Department has met extensively with long term care facility representatives and consumer representatives to discuss the development of a standard admission agreement. The content of the proposed agreement, though not the specific language, reflects a general consensus about what the agreement should address. There were two areas

in which consensus could not be reached: 1) inclusion of a reference to arbitration agreements within the standard agreement itself and attachment of an arbitration agreement thereto, and 2) whether a standard admission agreement represented an unconstitutional abridgement of the "freedom of contract."

With respect to arbitration, the proposed standard admission agreement contains no mention of arbitration and provides no attachment to accommodate an arbitration agreement. The rationale for the Department's determination in this regard is presented in the Initial Statement of Reasons discussion regarding "Subsection d" of the proposed regulation text.

With respect to the constitutional argument, the Department is prohibited by Article III, Section 3.5 of the California Constitution from declaring a statute unconstitutional and from refusing to enforce a statute. In addition, the Department has attempted to provide for expected and appropriate variances among facilities by providing spaces to record facility-specific terms and including templates as attachments to record different services and related charges. The Department has attempted to craft a standard admission agreement that complies with all applicable state and federal laws, as required by Health and Safety Code Section 1599.61 (a).

Each section of the California Standard Admission Agreement is discussed below, with a brief justification for the inclusion of each sentence or group of sentences with the same purpose. All references to the Health and Safety Code are abbreviated "HSC", all references to Title 22 of the Code of California Regulations are abbreviated "22CCR", and all references to Title 42 of the Code of Federal Regulations are abbreviated "42CFR."

I. Preamble

The Preamble provides general information to introduce the prospective resident to the nature of the document.

This is an admission contract that this Facility is required by state law and regulation to use. This informs the resident that the facility must use this document as its admission agreement, consistent with the provisions of HSC 1599.61 and these proposed regulations.

It is a legally binding agreement that defines the rights and obligations of each person (or party) signing the contract. This acknowledgement makes it clear that the admission agreement is a legal document defining the rights and obligations of persons signing the agreement. The parenthetical inclusion of the phrase "or party" simply serves to introduce this common contracting term to the resident as meaning the same thing as "person signing the contract."

Please read the agreement carefully before you sign it. If you have any questions, discuss them with Facility staff until you are satisfied that you understand. You are encouraged to have this contract reviewed by your legal representative, or by any other advisor of your choice, before you sign it. This is an important advisory to prospective residents, to the effect that they should carefully review, and be satisfied with their understanding of, the contract before signing it. HSC 1599.65 imposes on facilities the duty to make reasonable efforts to communicate the content of the contract to the prospective resident.

You may also call the office of the State Long Term Care Ombudsman at a toll-free number, 1-800-231-4024, to discuss this admission agreement or for more information about our Facility. This sentence advises the prospective resident that additional help is available from the office of the State Long Term Care Ombudsman, a state agency whose purpose is to provide this kind of help. HSC 1599.85 requires that all contracts of admission contain the following advisory: "For more information about our facility, you may call the State Ombudsman's Office at (insert toll free number)." The language proposed for the standard admission agreement is not identical to that required by statute: however, it achieves the same purpose. The minor changes in language are intended to more accurately identify the State Ombudsman's Office by using its complete title, and to specifically include the notion that the resident may discuss the admission agreement with the Ombudsman's Office.

Reports of state inspections of our Facility are posted here at the Facility, and a copy may be obtained from the local office of the California Department of Health Services (DHS), Licensing and Certification Division. This sentence advises prospective residents that the findings of inspections performed by the Licensing and Certification Division of the Department of Health Services, are available in the facility and from the local office of the Licensing and Certification Division. HSC 1599.87 requires the Department to develop a list of approximately 25% of long term care facilities with the most serious records of violations. This HSC Section also requires facilities on this list to include the following specific statement on their contracts of admission: "This facility's record of citations is posted at the facility, and a copy may be obtained from the Department of Health Services." However, this statutory requirement predates the requirement that the Department develop a standard admission agreement for use by all skilled nursing and intermediate care facilities. In order to develop a standard agreement for use by all of these facilities (75% of which would not be required to carry this advisory in their admission agreement) and recognizing the Legislature's intent that prospective residents be advised in the admission agreement that information about licensing inspections is available, the Department proposes to include this sentence. 22CCR 72503 requires facilities to conspicuously post in a prominent location accessible to the public the "Most recent licensing visit report supported by the related follow-up plan of correction visit reports." Accordingly, this provision of the standard admission agreement imposes no new requirement and

meets the Legislative intent that prospective residents be advised that information about licensing inspections is available to them.

If you are able to do so, you are required to sign this Agreement in order to be admitted to this Facility. If you are not able to sign this Agreement, your representative may sign it for you. You shall not be required to sign any other document at the time of, or as a condition of, admission to this Facility. These sentences simply advise the resident that he or she must sign the admission agreement in order to be admitted to the facility, but no other document is required to be signed. This is consistent with the definition of "contract of admission" contained in HSC 1599. 60 (b) as including "all documents which a resident ... must sign", and with HSC 1599.65 (a) which provides that "the facility shall make reasonable efforts to ... obtain on the contract the signature of the person who is to be admitted to the facility". HSC 1599.65 (a) further provides, "In the event the patient is unable to sign the contract, the reason shall be documented in the resident's medical record by the admitting physician." Accordingly, the law allows for admission to a facility when neither the resident nor a representative acting on the resident's behalf signs the admission agreement.

II. Identification of Parties to this Agreement

In order to make this Agreement more easily understood, personal pronouns are used where practical in referring to the parties signing the Agreement.

References to "we", "our", "us", "the Facility", or "our Facility" are references to

_____.

(Insert the Name of the Facility as it appears on its License)

References to "you", "your", or "Resident" are references to the person who will be receiving care in this Facility or the Resident's Representative. Note that federal or state laws and regulations which apply to this Facility and persons receiving care in this Facility use the terms "Resident" and "Patient" interchangeably. For purposes of this Agreement, "Resident" has the same meaning as "Patient". In these sentences, the Department expresses its intent to make this admission agreement an easily understood document, in part by using personal pronouns in referring to the parties to the agreement. Though this is not specifically required by law, contracts often contain provisions, which formally identify the parties and introduce plain language terms that will be used in the contract when referring to one or the other of those parties. Clarification of the term "Resident" is also provided, consistent with the explanation provided on page 1 of this Initial Statement of Reasons. Inclusion of this clarification is particularly important for any residents who wish to conduct their own review of the actual text of statutes and regulations governing the agreement.

A Resident's Representative may include a conservator, a person designated under the Resident's Advance Directive or Power of Attorney for Health Care, the Resident's

next of kin, any other person designated by the Resident consistent with State law, a person authorized by a court, or, if the Resident is a minor, a person authorized by law to represent the minor. HSC 1599.65 uses several terms to identify persons who may act on the resident's behalf, including "legal representative", "responsible party", and "agent", but these terms are not defined in statute. This definition of Resident's Representative is drawn from 22CCR 72527 (d), which specifies who may act as a Resident's Representative as follows: "Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor."

A Resident's Representative who signs this Agreement on behalf of the Resident assumes no personal financial liability for the care provided to the Resident by the Facility. This provision advises both the resident and the resident's representative, that a resident's representative, by signing this agreement on the resident's behalf, does not assume personal responsibility for covering the cost of care for the resident. If the resident's representative has legal control of the income and assets of the resident (for example, as a conservator), then that representative has the authority and separate legal responsibility to use the resident's assets and income to pay for the costs of care provided to the resident – but that representative has no personal financial liability. The signature of the resident's representative on this document only acknowledges, on behalf of a resident who cannot do so for him-or-herself, that they understand the contents of the admission agreement and agree to abide by its terms.

IF OUR FACILITY PARTICIPATES IN THE MEDI-CAL OR MEDICARE PROGRAM AND IF YOU ARE ELIGIBLE FOR ONE OR BOTH OF THOSE PROGRAMS, OUR FACILITY DOES NOT REQUIRE THAT YOU HAVE ANYONE GUARANTEE PAYMENT FOR YOUR CARE BY SIGNING OR COSIGNING THIS ADMISSION AGREEMENT AS A CONDITION OF ADMISSION. HSC 1599.65 (b) requires that a contract of admission for facilities participating in Medi-Cal "set forth, in bold capital letters ... the prohibition ... that no facility may require or solicit as a condition of admission that a Medi-Cal beneficiary have a responsible party sign or cosign the contract of admission." The Department's interpretation of the Legislative intent of this provision was to prohibit facilities from requiring that someone sign or cosign the admission agreement as the person responsible for making payments to the facility on the resident's behalf. This interpretation is reasonable since the State of California, via the Medi-Cal program, is the guarantor of payment for Medi-Cal beneficiaries. Further, 42CFR 483.12 (d) (2) provides that no facility certified for participation in Medicare or Medi-Cal may "require a third party guarantee of payment to the facility as a condition of admission". On the other hand, a facility that does not participate in

Medi-Cal or Medicare may require a financial guarantor, but that would be a separate compensation agreement with that guarantor and could involve a person other than the resident or the resident's representative.

The Parties to this Agreement are:

Resident: _____.
(Type or Print Resident's Name Here)

Resident's Representative: _____.
(Type or Print Representative's Name Here)

Title: _____.

Facility: _____.
(Enter the Facility's Name as it appears on the License)

This provision is not required by state law to be included in the admission agreement. However, the Department has determined that it is consistent with standard practice to include specific identification of the parties to this contract.

III. Consent to Treatment

By signing this Agreement, you consent to routine nursing care provided by this Facility, as well as emergency care that may be required. This sentence expresses the resident's consent to the nursing care that the facility is licensed to provide, and emergency care if it may be needed. HSC 1599.72 provides that "Contracts of admission may require consent only for routine nursing care or emergency care" and that "no contract of admission shall include a clause requiring residents sign a consent to all treatment ordered by a physician." The proposed agreement language is consistent with these provisions of law.

However, you have the right to refuse any treatment and the right to be informed of what may happen if you refuse treatment. We will keep you informed about the nursing care and medical care we provide to you, and we will answer your questions about the care and services we provide you. HSC 1599.72 requires that the admission contract contain a clause that informs the resident of the right to refuse treatment, consistent with the provisions of 22CCR 72527 (a) (4). While not specifically required by law, the Department proposes to include language which reflects the provisions of 22CCR 72527 (a) (5), regarding the resident's right to be fully informed regarding a decision to accept or refuse treatment. Further, 22CCR 72528 details informed consent obligations of facilities toward their residents.

If you are incapable of making your own medical decisions, or become so in the future, we will follow the direction of a legally authorized alternative health care decision-maker, such as a guardian, conservator, a person designated in an Advance Directive or Power of Attorney for Health Care, or other persons authorized by law to make decisions on your behalf. This sentence advises prospective residents that, if

they are not able to make medical decisions on their own, specified other persons may act on their behalf. Although not specifically required by law, this provision is important so that both the facility and the resident know how medical decisions will be made if the resident cannot make them, and is consistent with 22CCR 72527 (d). Further, HSC 1418.8 specifies how the determination of a resident's capacity to make medical decisions is to be ascertained and recorded, and how those medical decisions are to be made if the resident is incapable of making them.

You may provide us with an Advance Directive specifying your wishes as to the care and services you want to receive in certain circumstances. You are not required to prepare an Advance Directive, or to provide us a copy of one, as a condition of admission to our Facility. However, if you do have an Advance Directive, it is important that you provide us with a copy so that we may inform our staff to ensure that your wishes are respected. This paragraph advises prospective residents that they may also express their treatment preferences through an Advance Directive. HSC 1599.73 provides that "After admission, the facility shall encourage residents having the capacity to make health care decisions to execute an advance health care directive ... " Accordingly, neither the preparation of an Advance Directive, nor the provision of a copy of one, can be a condition of admission to the facility. On the other hand, residents are advised here that, if they do have an Advance Directive, they should provide it to the facility so that the facility may take appropriate steps to ensure its provisions are respected.

If you do not have an Advance Directive and wish to prepare one, we will assist you in doing so. As noted above, HSC 1599.73 clearly requires facilities to encourage residents to prepare an Advance Directive if they do not already have one.

IV. Your Rights as a Resident

Residents of this Facility keep all their basic rights and liberties when they are admitted. Because these rights are so important, both federal and state laws and regulations describe them in detail, and state law requires that a comprehensive summary of them be attached to this Agreement. This paragraph introduces residents to the fact that they lose no rights by virtue of their admission to the facility. In fact, they are advised that state and federal laws and regulations describe specific rights in detail. HSC 1599.61 (d) requires that the Department develop a comprehensive resident bill of rights, and that this bill of rights be included as an attachment to the admission agreement.

Attachment A, entitled "Resident Bill of Rights", summarizes your rights in everyday language. If you wish to review the actual laws and regulations in which these rights are expressed, you may find them in Section 1599.1 of the California Health and Safety Code, Section 72527 of Title 22 of the California Code of Regulations, and Part 483 of Title 42 of the Code of Federal Regulations. Willful or repeated violations of

state laws and regulations identified above may subject our Facility and our staff to civil or criminal proceedings. You have the right to voice grievances to us without fear of any reprisal, and you may submit complaints or any questions or concerns you may have about our services or your rights to the local office of the DHS Licensing and Certification Division. This paragraph directs prospective residents to Attachment A to find the comprehensive summary of resident rights. It also contains certain advisories that are specifically required by HSC 1599.2 to appear on written materials informing residents of their rights. The Department has expanded the advisory with respect to residents' ability to submit complaints to the Department to make it clear to residents that they may direct any questions or concerns to the Department's Licensing and Certification Division.

You should review the attached "Resident Bill of Rights" very carefully. To acknowledge that you have been informed of the "Resident Bill of Rights", please sign here:

_____. This language advises the prospective resident to review the bill of rights carefully, and requests written acknowledgement that the resident has been informed of his or her rights. HSC 1599.74 (c) requires that the admission agreement "contain a separate written acknowledgement that the resident has been informed of the Patient's Bill of Rights. Written acknowledgement by the resident or the resident's representative must be made either on a separate document or in the admission agreement itself next to the clause informing the resident of these regulatory rights. Written acknowledgement by use of the signature on the agreement as a whole does not meet this requirement." The Department considered the option of including this acknowledgement on Attachment A, Resident Bill of Rights, as allowed by law. The decision to place the written acknowledgement here is intended to call residents' particular attention to these important rights early on in their review of this agreement. As well, the Resident Bill of Rights is a document that the Department intends to circulate widely to the public, and everyone receiving this document need not acknowledge receipt – only persons who are being admitted to a facility are required to acknowledge receipt of this information.

It should be noted here that HSC 1599.74 (b) appears to require that every contract of admission contain a complete verbatim copy of both the statutory and regulatory bill of rights. The Department does not propose to include any other attachment to the Standard Admission Agreement relative to Resident Rights. To do so would be redundant and would likely cause confusion. Further, HSC 1599.61 (d) provides that "This comprehensive Patients' Bill of Rights shall be a mandatory attachment to all ... contracts as specified in Section 1599.74 of this chapter." The Department's interpretation of this provision is that the Legislature specifically intended that the consolidated, comprehensive Resident Bill of Rights required by HSC 1599.61 (d) be used to satisfy the requirement of HSC 1599.74.

V. Financial Arrangements

Beginning on _____ *, we will provide nursing facility care and services to you in exchange for payment.* This provision is not specifically required by law, but is essential for both the resident and the facility to know the exact day on which the resident will be admitted for care in the facility. It is also an essential provision of the contract – the value to be exchanged.

(Month, Day, and Year of Admission)

Our Facility has been approved to receive payment from the following government insurance programs: ☐ ***Medi-Cal*** ☐ ***Medicare***
HSC 1599.66 requires that "every contract of admission clearly and explicitly state whether the facility participates in the Medi-Cal program." The law does not require the same for Medicare but, since Medicare is a large government program which pays for skilled nursing facility care, it is important for a resident to know whether the facility is eligible to receive Medicare reimbursement for care provided to that resident.

At the time of admission, payment for the care we provide to you will be made by:

☐ ***Resident (Private Pay)*** ☐ ***Medi-Cal*** ☐ ***Medicare***

☐ ***Resident's Private Insurance:*** _____

_____
(Enter Insurance Company Name, and Policy Number)

This provision of the agreement is not specifically required by law: however, it is very important for both the facility and the resident to clearly understand and agree how the facility will be paid for the care provided to the resident.

If our Facility participates in Medi-Cal or Medicare and you do not know whether your care in our Facility can be covered by Medi-Cal or Medicare, we will help you get the information you need. This provision is not specifically required by law: however, federal regulations (42CFR 483.10 (b) (10)) do require that facilities which participate in Medicare or Medi-Cal must assist residents in determining whether they qualify for benefits under these programs. Accordingly, this requirement only applies to facilities certified for participation in Medicare or Medi-Cal.

You should note that, if our Facility does not participate in Medi-Cal or Medicare and you later want these programs to cover the cost of your care, you may be required to leave our Facility. This provision is simply an advisory to residents who may be considering admission to a facility that is not certified for Medi-Cal or Medicare participation that, should they later want to take advantage of the benefits provided by these government programs, they may be required to leave the facility – since the facility is not eligible to receive payments from either program.

YOU SHOULD BE AWARE THAT NO FACILITY THAT PARTICIPATES IN THE MEDI-CAL PROGRAM MAY REQUIRE ANY RESIDENT TO REMAIN IN PRIVATE PAY STATUS FOR ANY PERIOD OF TIME BEFORE CONVERTING TO MEDI-CAL COVERAGE. HSC 1599.69 (a) requires several notifications that must be included in all admission agreements and must be presented in "bold capital letters of not less than 10-point type." The first requirement is notification that no resident "may be required to pay privately for any period during which the resident has been approved for payment by Medi-Cal." The second required notification is that "the facility shall return any and all payments made by the beneficiary ... for Medi-Cal program covered services upon receipt of Medi-Cal payment." The third required notification is that "no certified facility may require as a condition of admission ... that residents remain in private pay status for a specified period of time." This proposed paragraph of the standard admission agreement provides the last of these three notifications. The proposed location of this advisory flows in logical sequence in this introductory discussion of payment arrangements. It should be noted here that the 10-point type requirement was superseded by the adoption of HSC 123222.1, which requires use of at least 12-point type in a variety of documents (including admission papers). The 14-point format of the proposed agreement meets both of these statutory standards. As noted below, the first notification fits logically in section V. A. below, and the second notification fits logically in section V. B. below.

A. Charges for Private Pay Residents

Our Facility charges the following basic daily rates:

$ _____ for a private, single bed room

$ _____ for a room with two beds

$ _____ for a room with three beds

$ _____ for _____
(Specify any other accommodation here)

The basic daily rate for private pay residents includes payment for the services and supplies described in Attachment B-1. This portion of the admission agreement specifies the daily rate that will be charged to a resident who is paying for his or her own care out of personal resources and describes the nursing services that are covered under the daily rate. HSC 1599.67 (a) requires that every contract of admission "state clearly what services and supplies are covered by the facility's basic daily rate." In order to accommodate appropriate differences between facilities with respect to what services and supplies are covered by the basic daily rate, Attachment B-1 is a standard template for facilities to list those services and supplies covered by the basic daily rate.

The basic daily rate will be charged for the day of admission, but not for any day beyond the day of discharge or death. However, if you are voluntarily discharged from the Facility less than three days after the date of admission, we may charge you for a maximum of three days at the basic daily rate. This provision is essential for both the facility and the resident to know and agree on when the requirement for payment starts and stops. HSC 1599.71 (a) provides that no admission contract "shall require the resident to pay for days beyond the date of his or her death or involuntary discharge, except that a facility may charge a resident for a maximum of three days at the basic daily rate in the event that the resident is voluntarily discharged from the facility less than three days following his or her admission." The Department's interpretation of Legislative intent regarding this provision is that no resident should be charged for any day after voluntary discharge, unless the stay in the facility was for less than three days.

We will provide you with a 30-day written notice before increasing the basic daily rate, unless the increase is required because the state increases the Medi-Cal rate to a level higher than our regular rate. In this case, state law waives the 30-day notification. HSC 1599.67(c) requires that every contract of admission clearly state that the facility is required to "provide no less than 30 days written notice ... of any increase ... in the daily room rate, except as provided in subdivision (b) of Section 1288." The exception allowed in HSC 1288 (b) relates to the fact that facilities are prohibited by law from charging the Medi-Cal program a daily rate that is higher than the daily rate charged to private pay residents. When Medi-Cal payment rates change as a result of emergency regulations or are made retroactive, the facility has no advance notice of the change in Medi-Cal rates. This precludes the possibility of providing 30-days notice to residents and, if the exception were not available, the facility would be unable to bill Medi-Cal at the newly adopted Medi-Cal rate since private pay rates would then be lower than the newly adopted Medi-Cal rate.

***Attachment B-2** lists optional supplies and services not included in our basic daily rate, and our charges for those supplies and services.* HSC 1599.67 (a) requires that the admission agreement specify in detail which services are optional, and the charges for these services. The Department proposes to meet this requirement in the context of this standard admission agreement by referring to an attached standard template that each facility must fill out listing the optional services the facility makes available to residents if they wish to pay for them and the prices charged.

We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. State law does not specifically require that facilities must charge residents only for optional supplies and services that the resident specifically requests. However, the Department believes that this is a reasonable requirement, one, which does apply to all facilities certified for participation in Medi-Cal or Medicare. 42CFR 483.10 (c)(8)(iii) provides

"The facility must not charge a resident ... for any item or service not requested by the resident." Further, it is essential for the facility and the resident to have a clear agreement on this point so that: a) the facility does not provide services, and charge the resident for them, if the resident has not requested them, and b) the resident does not expect the facility to provide optional services the resident has not requested.

We will provide you a 30-day written notice before any increase in charges for optional supplies and services. HSC 1599.67 (c) requires "30 days written notice to the residents of any increase for optional services or in the daily room rate charged ..." While the Legislature did not specify that this notice requirement applies to increases in charges for optional supplies, it did specify that the notice applies to increases in charges for optional services. The Department believes it is a reasonable interpretation that the Legislature intended that 30-day notice be given for any increase in charges for optional supplies, as well as for services.

If you become eligible for Medi-Cal at any time after your admission, the services and supplies included in the daily rate may change, and also the list of optional supplies and services. We will review ***Attachments C-1, C-2 and C-3*** *with you to explain any changes in coverage.* HSC 1599.67 (b) requires that admission agreements for facilities that participate in Medi-Cal or Medicare indicate that optional and covered services may be different for residents in those programs than for private pay residents. It also requires that, when a resident converts to Medi-Cal coverage, the facility must give the resident a form listing Medi-Cal optional and covered services.

IF YOU ARE APPROVED FOR MEDI-CAL COVERAGE AFTER YOU ARE ADMITTED TO OUR FACILITY, YOU MAY BE ENTITLED TO A REFUND. WE WILL REFUND TO YOU ANY PAYMENTS YOU MADE FOR SERVICES AND SUPPLIES WHICH ARE LATER PAID FOR BY MEDI-CAL, LESS ANY DEDUCTIBLE OR SHARE OF COST. WHEN OUR FACILITY RECEIVES PAYMENT FROM THE MEDI-CAL PROGRAM, WE WILL ISSUE A REFUND TO YOU. As noted above, HSC 1599.69 (a) requires several notifications that must be included in all admission agreements. The second required notification is that "the facility shall return any and all payments made by the beneficiary ... for Medi-Cal program covered services upon receipt of Medi-Cal payment."

B. Charges for Medi-Cal, Medicare, or Insured Residents

If you are entitled to benefits under these programs and if we participate as a provider in those same programs, we agree to accept payment from them instead of our basic daily rate. This provision is not required by statute to be included in the admission agreement. However, the facility will have already agreed to accept payment from these programs by virtue of the fact that they participate in one or all of the programs. It is an essential term of the contract that both the facility and the resident agree that

payments from these programs will be accepted by the facility in lieu of payment by the resident.

YOU DO NOT NEED TO PAY FOR ANY MEDI-CAL COVERED SERVICES PROVIDED TO YOU DURING THE TIME YOU ARE ELIGIBLE FOR MEDI-CAL BENEFITS. As noted above, this is one of the three notifications required to be included in the admission agreement, pursuant to HSC 1599.69 (a). It is more appropriately located here, rather than with the other two notifications addressed above, because this part of the contract deals with charges for Medi-Cal eligible residents.

However, you are still responsible for paying all deductibles, copayments, coinsurance, and charges for services and supplies that are not covered by Medi-Cal, Medicare, or your insurance. Please note that our Facility does not determine the amount of any deductible, copayment, or coinsurance you may be required to pay; rather, Medi-Cal, Medicare, or your insurance carrier determines these amounts. These sentences are not required by law to be included in the admission agreement. However, they are statements of fact and it is essential that both the facility and the resident agree that charges that are not covered by a governmental or private insurer must be paid by the resident. They also serve to avoid confusion for residents who, because they are eligible for government benefits or have private insurance, might think that they will not be required to pay anything for the care provided by the facility.

Attachments C-1, C-2, and C-3 *describe the services covered by the Medi-Cal daily rate, services that are covered by Medi-Cal but are not included in the daily rate, and services that are not covered by Medi-Cal but are available if you wish to pay for them.*

Attachments D-1 and D-2 *describe the services covered by Medicare, and services that are not covered by Medicare but are available if you wish to pay for them.* The preceding two sentences implement the requirements of HSC 1599.67 that contracts of admission clearly identify the services and supplies that are covered under the daily rate and those that are optional, along with the prices charged for optional supplies and services. Attachments C-1 and C-2 were provided by the Medi-Cal program to describe services and supplies covered under the daily rate and other supplies and services which are covered by the Medi-Cal program but not under the daily rate. Attachment C-3 is a standard template that must be completed by each facility, listing the additional supplies and services that that particular facility makes available to Medi-Cal eligible residents if they wish to pay for them. Attachment D-1 describes the services covered by the Medicare program. Attachment D-2 is a standard template, which must be completed by each facility, listing those supplies and services that that particular facility makes available to Medicare residents if they wish to pay for them.

You should note that Medi-Cal will only pay for covered supplies and services if they are medically necessary. If Medi-Cal determines that a supply or service is not

medically necessary, we will inform you of that and ask whether you still want that supply or service and will pay for it yourself. Though not required by statute to be included in the admission agreement, this is an important advisory to avoid confusion for Medi-Cal residents. The Medi-Cal program maintains a process for determining the medical necessity of covered benefits and, if a benefit is not medically necessary, Medi-Cal will not pay for it. For example, Medi-Cal may determine that an electric wheelchair is not medically necessary for a resident and that a manual wheelchair will meet the resident's medical needs. In that case, Medi-Cal will not pay for the electric wheelchair. This provision requires the facility to inform the resident of the Medi-Cal determination that an otherwise covered supply or service is not medically necessary and determine whether the resident wishes to purchase that supply or service with their own resources. This is consistent with 42CFR 483.10 (c)(8)(iii) which provides "The facility must not charge a resident ... for any item or service not requested by the resident."

We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. We will provide you a 30-day written notice before any increase in charges for optional supplies and services. These two sentences are identical to two provisions discussed under A. Charges for Private Pay Residents, and the authority and references for inclusion are provided there. They are duplicated here to clarify that residents who have Medi-Cal, Medicare, or private insurance will only be charged for optional supplies and services that they request and will be given appropriate notice of any change in charges for those supplies and services.

C. Billing and Payment

We will provide to you an itemized statement of charges that you must pay from your own resources every month. HSC 1599.67 (a) requires that "Every contract of admission ... indicate that residents will receive monthly statements itemizing all charges incurred by them."

You agree to pay the account monthly on _____ (enter day of month). This sentence is not required by statute to be included in the admission agreement and there is no specific statutory requirement that residents pay monthly, or at all, for supplies and services provided by the facility and not covered by government or private insurance. However, by requiring the facility to provide a monthly-itemized statement, it follows that the Legislature expected residents to pay the account monthly. This is an essential term of the contract in order for the facility to have a contractual basis for timely collection of reimbursements from residents for services provided.

Payment is overdue _____ days after the due date. A late charge at an interest rate of _____ % is charged on past due accounts and is calculated as follows:

_____
_____
_____

HSC 1599.68 requires that "Any long-term health care facility that imposes interest on delinquent accounts shall clearly state in the contract of admission the rate of interest so charged and the method of computation. To meet this statutory requirement, since there are no statutory or regulatory definitions of "delinquent accounts", it is essential that both the facility and the resident specifically agree about when payment becomes past due. Similarly, since there are no statutory or regulatory standards regarding interest rates for past due accounts or the method for calculating late charges, the agreement must provide flexibility for the facility and the resident to negotiate and record these terms of the contract.

D. Security Deposits

If your care in our Facility is covered by Medi-Cal or Medicare, no security deposit is required. HSC 1599.70 (a) requires that "No contract of admission may require a security deposit from a Medi-Cal beneficiary who applies for admission to the facility as a Medi-Cal resident". 42CFR 489.22 prohibits Medicare providers from requiring prepayment in whole or part from Medicare eligible persons for covered inpatient services, unless it is clear upon admission that Medicare cannot pay for those services.

If you are a private pay or privately insured Resident, we require a security deposit of $_____. We may use the funds in the security deposit as follows:

_____
_____
_____

We will return the security deposit to you, with no deduction for administration or handling charges, within 14 days after you close your private account or we receive payment from Medi-Cal. State law does not prohibit facilities from collecting a security deposit from private pay or privately insured residents. Accordingly, a security deposit may be required for such residents, and this part of the standard agreement allows the facility and the resident to negotiate and record a mutually agreeable security deposit. As well, this provision provides space for the facility and the resident to agree on and record how security deposit funds may be used. HSC 1599.70 (b) requires that "any security deposit from a person paying privately upon admission shall be returned within 14 days of the private account being closed, or first Medi-Cal payment, whichever is later, and with no deduction for administration or handling charges."

E. Payment of Other Refunds Due To You

As indicated in Sections V. A. and D. above, refunds may be due to you as a result of Medi-Cal paying for services and supplies you had purchased before your eligibility for Medi-Cal was approved or for any security deposit you may have made. At the time of your discharge, you may also be due other refunds, such as unused advance payments you may have made for optional services not covered by the daily rate. We will refund any money due to you within 14 days of your leaving our Facility. We will not deduct any administration or handling charges from any refund due to you.
This provision is not required by state law to be included in the admission agreement, nor does state law specifically apply the requirement for payment of refunds within 14 days and prohibition of deduction for administrative expenses to any refund other than a security deposit refund. However, since there may be other refunds due to the resident and this contract should address any standards for payment of such refunds, the Department believes it is a reasonable interpretation of Legislative intent that any and all refunds due to the resident be paid by the facility according to the specific terms adopted by the Legislature for refunds of security deposits. As well, 22CCR 72531 requires that any advance rental payments be returned to the resident or their representative no later than two weeks after the resident's discharge or death.

VI. Transfers and Discharges

You may leave our Facility at any time without prior notice to us. We will help arrange for your voluntary discharge or transfer to another facility. HSC 1599.71 (b) provides "no contract of admission shall require advance notice of voluntary discharge from a facility. 22CCR 72433 (5) requires all licensed facilities to provide "Discharge planning for each patient and implementation of the plan."

Except in an emergency, we will not transfer you to another room within our Facility, or to another facility, and we will not discharge you from our Facility against your wishes unless we give prior written notice to you. HSC 1599.78 provides "All contracts of admission shall state that except in an emergency, no resident may be involuntarily transferred within or discharged from a long-term health care facility unless he or she is given reasonable notice in writing ..."

Our written notice of transfer or discharge against your wishes will be provided 30 days in advance. However, we may provide less than 30-day notice if the reason for the transfer or discharge is to protect your health and safety or the health and safety of other individuals, if your improved health allows for a shorter notice, or if you have been in our Facility for less than 30 days. Our written notice will include the effective date, the location to which you will be transferred or discharged, and the reason the action is necessary. The only reasons that we can transfer or discharge you against your wishes are:

1) It is required to protect your well-being, because your needs cannot be met in our Facility;

2) It is appropriate because your health has improved enough that you no longer need the services of our Facility;

3) Your presence in our Facility endangers the health and safety of other individuals;

4) After reasonable and appropriate notice, you have not paid for your stay in our Facility or have not arranged to have payment made under Medicare, Medi-Cal, or private insurance;

5) Our Facility ceases to operate;

6) Material or fraudulent misrepresentation of your finances to us.

As noted above, HSC 1599.78 requires "reasonable notice in writing". It also requires that the "notice shall state the reason for the transfer or discharge." In this admission agreement, the Department is defining "reasonable notice" in a manner consistent with federal regulations which apply to facilities certified for participation in Medi-Cal or Medicare. 42CFR 483.12 (a) (4), (5), and (6) require written notice at least 30 days before the resident is transferred or discharged, except in specified circumstances, and require the notice to include the reason, the effective date, and the location to which the resident will be transferred. The 30-day requirement is also consistent with HSC 1336.2 (c) which requires a 30-day written notice to residents if they must be transferred due to any change in the status of the license or the operation of the facility such that the facility can no longer care for the residents. HSC 1599.76 (a) provides that "No contract of admission shall list any ground for involuntary transfer or discharge of the resident except those grounds that are specifically enumerated in either federal or state law." 42CFR 483.12 (a) (2) lists reasons 1 through 5 above as the only reasons a certified facility may transfer or discharge a resident. Reason number 6 reflects state law. HSC 1439.7 allows facilities to evict private pay residents under certain circumstances involving resident misrepresentation of their assets and liabilities. HSC 1599.77 (a) provides that "Contracts of admission shall speak only of 'material' or 'fraudulent' misrepresentation of finances as possible grounds for discharge under that section" (referring to HSC 1439.7).

If we participate in Medi-Cal or Medicare, we will not transfer or discharge you solely because you change from private pay or Medicare to Medi-Cal payment. We also will not require you to move from one bed to another bed solely because one is Medicare-certified and not the other. HSC 1599.76 (b) provides that "Every contract of admission to a long-term health care facility that participates in the Medi-Cal program shall state that the facility may not transfer or seek to evict any resident solely as a

result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal." Federal regulations do not allow certified facilities to transfer or discharge a resident by virtue of a change in their payment status, since that reason is not listed in federal regulation as an acceptable one. Further, 42CFR 483.10 (o) establishes a right of residents to refuse bed-to-bed transfers simply because of the certification status of the bed.

In our written notice, we will advise you that you have the right to appeal the transfer or discharge to the Department of Health Services, Licensing and Certification Division, and we will also provide the name, address and telephone number of the State Long-Term Care Ombudsman. As noted above, 42CFR 483.12 (6) specifies the content of a written notice of transfer or discharge. In addition to the effective date, reason, and location to which the resident will be transferred, this federal regulation requires the notice to include "A statement that the resident has the right to appeal the transfer or discharge to the State" and "The name, address and telephone number of the State long term care ombudsman." The Department has determined that it is appropriate to include this information in the "reasonable notice" required by statute, since it provides the resident with contact information if they have concerns with a proposed involuntary transfer or discharge.

If you are transferred or discharged against your wishes, we will provide transfer and discharge planning for continuing care. HSC 1599.78 provides that "All contracts of admission shall state that except in an emergency, no resident may be involuntarily transferred within or discharged from a long-term health care facility unless he or she is given ... transfer or discharge planning as required by law."

VII. Bed Holds and Readmission

If you must be transferred to an acute hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you. HSC 1599.79 requires that contracts of admission meet the requirements of 22CCR 72520. That section imposes no requirements with respect to admission agreements, but rather establishes bed hold standards. However, since the Legislature included this provision in a section of law that deals with admission agreement content requirements, the Department concluded that the Legislature intended that specific information about bed hold standards be included in admission agreements. Accordingly, these two sentences are included to reflect requirements in HSC 1599.79 that facilities "offer to hold a bed for the resident in the event the resident must be transferred to an acute care hospital for seven days or less" and that "The resident or the representative for the resident has 24 hours from receipt of the notice to request the bedhold."

If Medi-Cal is paying for your care, then Medi-Cal will pay for up to seven days for us to hold the bed for you. HSC 1599.79 requires that "the facility shall inform the resident that Medi-Cal will pay for up to seven bedhold days." While not specifically required to be included in the admission agreement, its inclusion in this part of the admission agreement is consistent with the Department's conclusion that the Legislature intended that such information be included in the contract of admission and this location of the information within the agreement follows logically from the previous notifications.

If you are not eligible for Medi-Cal and the daily rate is not covered by your insurance, then you are responsible for paying $ for each day we hold the bed for you. You should be aware that Medicare does not cover costs related to holding a bed for you in these situations. These sentences are not required by statute to be included in the admission agreement. However, having informed prospective residents that if they are eligible for Medi-Cal then Medi-Cal will pay for up to seven bedhold days, it is necessary to advise residents who are not eligible for Medi-Cal that, as provided in 22CCR72520 (a) (2), they are liable to pay bedhold charges unless they are a covered benefit under another insurance program. To minimize possible resident confusion in this regard, the factual statement that Medicare does not cover bedhold charges is also included.

If we do not follow the notification procedure described above, then we agree to offer you the next available appropriate bed in our Facility. HSC 1599.79 requires that "The contract of admission shall state that the facility shall offer the next available appropriate bed to the resident in the event the facility fails to follow this required procedure."

You should also note that, if our Facility participates in Medi-Cal or Medicare and you are away from our Facility for more than seven days due to hospitalization or other medical treatment, we will readmit you to the first available bed in a semi-private room if you need the care provided by our Facility and wish to be readmitted. This provision is not required by state law to be included in the admission agreement. However, 42CFR 483.12 (b) (3) does impose this requirement on certified facilities and the Department believes it is appropriate to include this provision here in the admission agreement to provide a complete description of readmission provisions.

VIII. Personal Property and Funds

Our Facility has a theft and loss prevention program as required by state law. At the time you are admitted, we will give you a copy of our policies and procedures regarding protection of your personal property, as well as copies of the state laws that require us to have these policies and procedures. These sentences are not required by state law to be included in the admission agreement. However, because of the importance of this issue to prospective residents, the Department has determined that

it is appropriate to advise prospective residents in the admission agreement that state law requires facilities to have theft and loss prevention programs. HSC 1418.7 requires facilities to have theft and loss prevention programs that meet specific standards. HSC 1289.4 also imposes various requirements regarding a facility's responsibility to protect residents' personal property, and subdivision (l) requires that a facility's policies and procedures regarding theft and loss prevention be provided to new residents upon admission.

If our Facility participates in Medi-Cal or Medicare and you give us your written authorization, we will agree to hold personal funds for you in a manner consistent with all federal and state laws and regulations. If we are not certified for Medi-Cal or Medicare, we may offer these services but are not required to. You are not required to allow us to hold your personal funds for you as a condition of admission to our Facility. At your request, we will provide you with our policies, procedures, and authorization forms related to our holding your personal funds for you. These provisions are not required by state law to be included in the admission agreement. However, because of the importance of this issue to prospective residents, the Department has determined that it is appropriate to advise prospective residents regarding personal fund management services. 42CFR 483.10 (c) requires certified facilities to provide personal fund management services and establishes standards for such services. 22CCR 72529 also establishes standards for safeguarding residents' personal funds.

IX. Photographs

You agree that we may take photographs of you for identification and health care purposes. We will not take a photograph of you for any other purpose, unless you give us your prior written permission to do so. This provision is not required by state law to be included in the admission agreement. However, HSC 1599.80 allows facilities to photograph residents only for identification and health care purposes and provides that photographs for any other purpose must be authorized in advance "on a document separate from the admission agreement as a whole." Accordingly, the Department has determined that it is the intent of the Legislature that residents be required to consent to being photographed for identification or health care purposes within the admission agreement, since photographs are such an important element in assuring resident security and provision of appropriate care.

X. Confidentiality of Your Medical Information

You have a right to confidential treatment of your medical information. You may authorize us to disclose medical information about you to a family member or other person by completing the "Authorization for Disclosure of Medical Information" form in Attachment E. HSC 1599.73 requires that "Every contract of admission shall state that residents have a right to confidential treatment of medical information" and "The

contract shall provide a means by which the resident may authorize the disclosure of information to specific persons, by attachment of a separate sheet ..."

XI. Facility Rules and Grievance Procedure

You agree to comply with reasonable rules, policies and procedures that we establish. When you are admitted, we will give you a copy of those rules, policies, and procedures, including a procedure for you to suggest changes to them.

We will also give you a copy of our grievance procedure for resolution of any complaints you may have about our Facility. You may also contact the following agencies about any grievance or complaint you may have:

California Department of Health Services
Licensing and Certification District Office
Phone number: _____

(OR)

State Long-Term Care Ombudsman Program
Phone number: _____

HSC 1599.75 requires that the contract of admission: a) indicate that any rules adopted by a facility which must be observed by a resident must be reasonable; b) specify that a copy of the facility's grievance procedure is available; and, c) inform residents of their right to contact the Department of Health Services or the long-term care ombudsman. The appropriate entity within the Department for residents to contact is the local district office of the Licensing and Certification Division. Space is provided for the facility to enter the phone number of these two entities to facilitate resident contact with either or both of them if a need to do so arises. HSC 1599.61 (b) (3) allows facilities to distribute written explanations of facility-specific rules and procedures, but prohibits the inclusion of such written materials in the admission agreement.

XII. Entire Agreement

This Agreement and the Attachments to it constitute the entire Agreement between you and us with respect to your admission to our Facility. There are no other agreements, understandings, restrictions, warranties, or representations between you and us regarding your admission to our Facility. This Agreement supersedes any prior agreements or understandings regarding your admission to our Facility. This provision is not required by statute to be included in the admission agreement. However, it is very important that both the facility and the resident know and agree that the contents of this admission agreement are the only terms and conditions of

admission to the facility and that no other representations or understandings can be enforced as though they were a part of this contract of admission.

By signing below, the Resident and the Facility agree to the terms of this Admission Agreement:

Representative of the Facility	*Date*
Resident	*Date*
Resident's Representative – if applicable	*Date*

This provision is not required by statute to be included in the admission agreement. However, it is essential and consistent with standard practice that the parties to a contract have an appropriate space to indicate their agreement to the contract by placement of their signatures or the signatures of authorized representatives.

Attachment A: Resident Bill of Rights

HSC 1599.61 (d) requires that the Department develop a consolidated and comprehensive Resident Bill of Rights. It also requires that this Resident Bill of Rights be a mandatory attachment to all contracts of admission.

In developing the "Resident Bill of Rights" which is proposed as Attachment A to the Standard Admission Agreement, the Department did not add to, detract from, interpret, or otherwise make specific the statutory and regulatory rights defined in HSC Chapter 3.9 (commencing with Section 1599), 22CCR 72527, 22CCR 73523, and 42CFR 483.10 et sequitur. Attachment A merely states those rights in plain language, and includes captions that provide specific references to relevant state law and regulation, as well as federal regulation.

Attachment B-1: Supplies and Services Included in the Basic Daily Rate for Private Pay and Privately Insured Residents

Attachment B-2: Optional Supplies and Services Not Included in Basic Daily Rate for Private Pay and Privately Insured Residents

Attachments B-1 and B-2 are necessary to meet the Legislative mandate of HSC 1599.67 (a) that "Every contract of admission shall state clearly what services and supplies are covered by the facility's basic daily rate" and that "the agreement shall specify in detail which services are optional, and the charges for these services ..." These two attachments do not impose any new requirements, nor do they otherwise interpret or make specific statutory mandates. They simply provide a standard template for facilities to use as required by HSC 1599.67 and allow for essential

flexibility among facilities with respect to available services and pricing for private pay or privately insured residents.

Attachment C-1: Supplies and Services Included in the Basic Daily Rate for Medi-Cal Residents

Attachment C-2: Supplies and Services NOT Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately

These two attachments reflect the content of 22CCR 51321, 51123, and 51511, which define the services covered under the Medi-Cal Program. Attachment C-1 is required pursuant to HSC 1599.67. Attachment C-2 is not specifically required by statute. However, the Department has determined that is important to advise prospective Medi-Cal residents not only regarding what supplies and services are covered under the Medi-Cal basic daily rate and what optional services they may purchase with their own resources, but also that Medi-Cal covers a wide range of medical care services that are not paid for in the Medi-Cal daily rate, but that Medi-Cal will pay for. The attachments do not impose any new requirements, nor do they otherwise interpret or make specific statutory standards – they simply describe Medi-Cal covered services.

Attachment C-3: Optional Supplies and Services Not Covered By Medi-Cal That May Be Purchased By Medi-Cal Residents

This attachment is necessary to meet the legislative mandate of HSC 1599.67. It is a standard template on which each facility can record the optional supplies and services, and their respective prices, available for direct purchase by Medi-Cal residents. This list of optional supplies and services may be different from the list recorded on Attachment B-2 since the supplies and services covered by the Medi-Cal program, either under the basic daily rate or otherwise, may be different from the supplies and services covered under the private pay daily rate or covered under a resident's private insurance. This attachment allows for essential flexibility among facilities with respect to the availability and pricing of optional supplies and services that may be purchased by Medi-Cal residents. It does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

Attachment D-1: Supplies and Services Covered by the Medicare Program For Medicare Residents

This attachment contains information excerpted from the brochure, "Your Medicare Benefits", which is published by the federal Centers for Medicare and Medicaid Services. This attachment is necessary since HSC 1599.67 requires a description of supplies and services covered under the Medicare basic daily rate, and those may differ from the supplies and services covered by the basic daily rate for private pay, privately insured, or Medi-Cal residents. Attachment D-1 is not as detailed as

Attachments C-1 and C-2, because the Department was unable after an extensive search to find comparably detailed descriptions of Medicare coverage published by the federal government and the Department has no authority itself to define Medicare benefits. This attachment is merely descriptive and does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

Attachment D-2: Optional Supplies and Services Not Covered by Medicare That May Be Purchased By Medicare Residents

This attachment is necessary to meet the legislative mandate of HSC 1599.67. It is a standard template on which each facility can record the optional supplies and services, and their respective prices, available for direct purchase by Medicare residents. This list of optional supplies and services may be different from the list recorded on Attachments B-2 or C-3 since the supplies and services covered by the Medicare program, either under the basic daily rate or otherwise, may be different from the supplies and services covered under the private pay daily rate, covered under a resident's private insurance, or covered by the Medi-Cal program. This attachment allows for essential flexibility among facilities with respect to the availability and pricing of optional supplies and services that may be purchased by Medicare residents.

Attachment E: Authorization for Disclosure of Medical Information

As noted earlier, this attachment is required pursuant to HSC 1599.73, which requires that "The contract shall provide a means by which the resident may authorize the disclosure of information to specific persons, by attachment of a separate sheet that conforms to the specifications of Section 56 of the Civil Code." Section 56 of the Civil Code simply provides that "This part may be cited as the Confidentiality of Medical Information Act." However, the Department has determined that the Legislature clearly intended that the authorization required by HSC 1599.73 conform to all the provisions of the Confidentiality of Medical Information Act. Civil Code Section 56.11 prescribes the requirements for a valid authorization for disclosure of medical information. Among other things, the authorization must be in at least 8-point type, be clearly separate from other language and executed by a signature which serves no other purpose than to execute the authorization, be signed by the resident or resident's representative, and state:

- "the specific uses and limitations on the types of medical information to be disclosed,"
- "the name or functions of the provider of health care ... that may disclose the medical information,"
- "the name or functions of the persons or entities authorized to receive the medical information,"

- "the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information,"
- "a specific date after which the provider of health care ... is no longer authorized to disclose the medical information," and
- that "the person signing the authorization" has "the right to receive a copy of the authorization."

Proposed Attachment E is a form developed by the Department to conform to the standards set in Civil Code Section 56.11. It does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

Exhibit 3

ADDENDUM II: 45-DAY PUBLIC COMMENTS/RESPONSES ON PROPOSED STANDARD ADMISSION AGREEMENT REGULATIONS R-05-01

1. Preamble: Review of Standard Admission Agreement by State Long Term Care Ombudsman

A. Comment: Statement on the first page of Standard Admission Agreement (Agreement) to "contact the Ombudsman to discuss this Admission Agreement" is incorrect, and not required by regulations or statutes. The words "to discuss this Admission Agreement" should be removed because the Ombudsman should not be put in the position of providing legal counsel regarding the Agreement.
Commenters: 1.1, 8.1, 20.1, 22.1, 28.1, 52.1-55.1, 57.1-71.1, 130.1-160A.1, 895.1, 896.9, 898.9, 912.3, PH 1.1

Department Response:
The Department of Health Services (Department, or DHS) agrees with this comment, and has made the recommended revision to the Agreement (page 1 of the post-hearing document).

B. Comment: Statement that a facility must review the contents of the Standard Admission Agreement with the resident until the resident "is satisfied" he/she understands it is not an appropriate contractual term. HSC §1599.65 requires that "the facility shall make reasonable efforts to communicate the content of the contract" with a resident.
Commenters: 524-554, 896.9, 898.8, 909.1

Department Response:
The Department acknowledges this comment, and made the appropriate change to the Agreement (page 1 of the post-hearing document).

C. Comment: Preamble language encouraging residents to have the Standard Admission Agreement reviewed by legal counsel before signing is inappropriate in a contract whose exact contents are dictated by law, since there is very little that an attorney could do to assist a prospective resident.

Further states that the recommendation to seek legal counsel suggests the resident needs protection from the facility, and introduces an element of distrust in a situation where the client typically need immediate care. The commenter adds that it would be helpful for residents to know that the terms of the contract are dictated by law, and suggests the following language be substituted in the Standard Admission Agreement for the sentence encouraging residents to seek legal counsel:

"This contract was written by the California Department of Health Services. Neither you nor the facility may alter the contract in any way."
Commenter: 911.5

Department Response:
The Department disagrees with this comment, and does not agree with the proposed revision. The Preamble specifically states that the Agreement is "legally binding," and residents are "encouraged to have this contract reviewed by your legal representative, or by any other advisor" before signing it.

Further, DHS does not believe that this it is inappropriate to encourage the use of an advisor or counsel for knowledgeable guidance; in certain cases, a resident might have no knowledge about the Standard Admission Agreement, nor any means of ascertaining whether it had been altered. Also, the proposed revision would not account for agreements legitimately altered through program flex changes. For these reasons, we do not agree that soliciting such advice interferes with good communications between facilities and residents.

2. Title 22 §72516(d) and §73518(d): Prohibition of voluntary arbitration agreements as part of the Standard Admission Agreement.
A. Comment: The prohibition against including a voluntary arbitration agreement is contrary to current law which allows a facility to include a binding arbitration clause in the Standard Admission Agreement as long as clauses are signed voluntarily by the resident and meet the statutory requirements. Commenters cite Health and Safety Code §1599.81, Code of Civil Procedures §1295 and case law (*Pietrelli v. Peacock* (1993) 16 Cal. Rptr.2d 688, 13 Cal. App.4th 943.)
Commenters: 2.1, 7.1, 13.1, 19.1, 25.1, 29.1, 33.1, 35.1, 37.1, 38.1, 41.1, 44.1-46.1, 49.1, 56.1, 72.1-129.1, 222.3-281.3; 889.2, 891.1, 893.1, 896.7, 898.5, 903.1, 907.1, 907.2, 908.5, 909.5, 911.2, 912.1, 913.2; PH 4.3

Department Response:
The Department does not agree that the regulations prohibit the use of arbitration agreements, but instead impose restrictions on their use. Based on its interpretation of the intent of SB 1061 (Chapter 631, Statutes of 1997) and Health and Safety Code §1599.60 et seq., as noted in the Initial Statement of Reasons, DHS has imposed a separation of the admission process from any discussion or presentation of an arbitration agreement, as well as an explicit acknowledgement that arbitration may not be imposed as a condition of admission or continued stay in a facility. Health and Safety Code §1599.81 is permissive, and mandates that:
(a) All contracts of admission that contain an arbitration clause shall clearly indicate that agreement to arbitration is not a precondition for medical treatment or for admission to the facility.
(b) All arbitration clauses shall be included on a form separate from the rest of the admission contract.

The Code of Civil Procedures §1295 is similarly permissive for contracts that contain arbitration clauses, but does not mandate that arbitration agreements be part of an admission agreement.

Additionally, SB 1061 (Chapter 631, Statutes of 1997) permits the addition of facility-specific rules and procedures, "provided that the written explanations are not included or incorporated in, or attached to the Standard Admission Agreement, nor signed by the resident or his or her representative" (emphasis added).

The case law cited did not involve the Department of Health Services, did not interpret HSC §1599.81, and does not pertain to Department operations.

B. Comment: The proposed regulations would effectively undermine the purpose of having an alternative dispute resolution process. Because of the difficulties of trying to get the parties together again to discuss signing an arbitration agreement after the admission process, the commenters assert that very few arbitration clauses would be signed. In addition, potential benefits of arbitration, such as accelerated settlements and reduced litigation costs, are lost to residents if arbitration agreements are prohibited.
Commenters: 2.2, 7.2, 13.2, 19.2, 25.2, 29.2, 33.2, 35.2, 37.2, 38.2, 41.2, 44.2-46.2, 49.2, 56.2, 72.2-129.2, 891.1, 893.1, 903.3, 908.5, 909.5, 911.2, 912.1

Department Response:
The Department disagrees, and believes that an arbitration agreement shall be separate from the Standard Admission Agreement. This does not "undermine" alternative dispute resolution processes. Moreover, this comment might be construed to imply that an arbitration agreement would not willingly be signed outside of the admission process. After a resident is admitted to a facility, one might assume there would be ample opportunity for a follow-up orientation meeting to review facility-specific procedures, including the option of signing an arbitration agreement, since the person would presumably reside full-time in the facility.

C. Comment: Presents a similar concern about violation of HSC §1599.81 as stated in Comment 2.A above, and adds that the Legislature neither repealed nor amended the provisions of §1599.81 when enacting the amendments to HSC §1599.61 that mandated a Standard Admission Agreement. States that an arbitration clause and attachment need to be added to the Agreement.
Commenters: 889.2, 896.2, 898.5, 907.1; PH 4.3

Department Response:
As previously noted, the Department disagrees, and believes that an arbitration agreement shall be separate from the Standard Admission Agreement. Nothing in HSC §1599.61 required the repeal of HSC §1599.81, since the latter clause is permissive and not mandatory.

D. Comment: Strongly supports the California Association of Health Facilities (CAHF) comments requesting that the Standard Admission Agreement include a voluntary arbitration provision. Agrees with Comment 2.A (above) that the prohibition is contrary to state law.
Commenter: 893.1

Department Response:
DHS disagrees; please refer to response to Comment 2.A.

E. Comment: Prohibition of arbitration is contrary to federal law, and the proposed regulatory provisions may be preempted by the Federal Arbitration Act. Cited case law: (*Allied-Bruce Terminex Cos., Inc. v. Dobson*, 513 U.S. 265, 272, citing *Southland Corp. v. Keating*, 465 U.S. 1, at 15-16).
Commenters: 893.1, 907.4

Department Response:
As previously noted, DHS is not prohibiting the use of arbitration. The case law cited did not involve the Department of Health Services, did not interpret HSC §1599.81, and does not pertain to Department operations.

F. Comment: As recently as January 9, 2003, the Director of Survey and Certification for the Centers for Medicare and Medicaid issued survey and certification guidance to the CMS Regional Offices regarding the use of binding arbitration. The guidance provides that utilization of binding arbitration agreements is an issue between the resident and the facility.
Commenter: 893.1

Department Response:
The Department disagrees with this interpretation of the CMS guidance referred to, which, if anything, emphasizes a resident's rights to arbitration on a completely voluntary basis. DHS believes that the proposed regulation furthers that goal.

G. Comment: Arbitration agreements must be excluded from the admissions process. Residents must clearly understand that arbitration is not required as a condition of admission. According to the Commenters, residents generally assume otherwise, and sign arbitration agreements not because they have made a conscious choice to commit themselves to arbitration, but because the arbitration agreement is part of a stack of papers presented at the time of admission. Residents sign because they believe that an agreement to arbitrate is routine, or because they feel that a refusal to sign will jeopardize the admission. Commenter suggested revising proposed 22CCR §72516 and §73518 to clarify that any arbitration agreement shall be presented after the date of admission, and cites HSC §1599.61(b)(3) to justify that nothing of a contractual nature other than the admission agreement be signed at the time of admission. Commenter states facilities' contention concerning HSC §1599.81 is without merit, and later-enacted statute prevails in the interpretation of conflicting statutes.
Commenter: 894.2; 897.1

Department Response:
DHS generally agrees with the direction of these comments, which conform with the proposed regulation that no other documents are permitted to be attached to the Standard Admission Agreement, or signed with the Agreement, as a condition of

admission. However, HSC §1599.61(b)(3) does not specify the timing of discussion of other agreements or documents, which could be considered following conclusion of admission. Hence the regulation will not be revised to further address the timing or presentation of an arbitration agreement.

H. Comment: What happens in practice is that arbitration is not a choice by residents in the vast majority of circumstances. A Commenter stated that he has never run into a resident or a resident's representative who says to him, "'Yes, I went to a nursing facility working on admission and what I really wanted to do was arrange for an alternative dispute resolution mechanism.'" The Commenter adds, "Nobody enters into that arrangement with that thought in mind. It's a fantasy to suggest otherwise."

These are provisions that are put in front of residents currently with the implication that it's just part of the routine process, that it is something that should be signed or has to be signed, and people just automatically sign it, having no understanding of what they're signing and certainly no conscious decision whatsoever to choose binding arbitration over some other form of dispute resolution. Arbitration should not be a part of the admission process. A facility has the right to suggest it, but it shouldn't be put in front of an individual's face at the time of admission.

If there is conflict between the two statutory provisions surrounding arbitration, it has to be reconciled in favor of the one subsequently enacted. The Legislature stepped forward and said that the nursing facility admission agreements were unwieldy and complicated and deceptive and asked that the Department draw up something accurate so that the deception would be stopped.
Commenter: PH 5.7

Department Response:
DHS acknowledges the Commenter's support of the regulations.

I. **Comment:** To emphasize that arbitration is not required as a condition of admission, the arbitration agreement should be presented to the resident no earlier than 48 hours after the Standard Admission Agreement has been signed.
Commenters: 895.2; PH 1.3

Department Response:
DHS does not agree that the regulation should address the timing of presentation of an arbitration agreement; see response to Comment 2.G above.

J. Comment: The Department does not have the power to restrict the ability for consumers and facilities to voluntarily enter into arbitration agreements, and it doesn't have the power to time the presentation or signing of a voluntary arbitration agreement in any particular way.
Commenter: PH 2.4

Department Response:
The Department agrees that it cannot prohibit arbitration. However, DHS has been authorized by law to develop a Standard Admission Agreement, and to develop specific regulations to implement it. As noted, HSC §1599.81(a) requires that residents be clearly notified that agreement to arbitration is not a precondition for admission or continued stay in a facility. Other than excluding presentation of an arbitration agreement with the Standard Admission Agreement, DHS is placing no restrictions upon use of an arbitration agreement, in compliance with the authority granted in the statutes.

K. Comment: Does not want arbitration to be mandatorily included as part of the Standard Admission Agreement, but that if chosen by a resident, it should and would be part of that Agreement. Would like an arbitration agreement to be included as an attachment to the Agreement, with a clear statement on the front page of the Agreement that a patient, or soon-to-be patient has a choice not to accept it.
Commenter: PH 2.4

Department Response:
DHS disagrees; please refer to response to Comment 2.J.

L. Comment: Commenter presents same argument presented in Comment 2.C above concerning the Legislature's intent by not amending or repealing HSC §1599.81. Also states that there is no prohibition against the inclusion of an arbitration agreement in the Standard Admission Agreement, as DHS would have you believe from its arguments in its Statement of Reasons. States that as a matter of fact, after HSC §1599.60 et seq. was first enacted in 1987, arbitration agreements were included in admission agreements and the reason for some of the provisions in HSC §1599.81 was to insure resident protections were included for admission agreements that used arbitration agreements. The very purpose of having the arbitration agreement clauses as attachments to the admission agreement was to ensure DHS' stated goal for these regulations in its Statement of Reasons to "prevent confusion and possible misrepresentation of documents to residents for signature after their admission."
Commenter: 896.2

Department Response:
DHS disagrees; please refer to response to Comment 2.C.

M. Comment: An arbitration clause has been part of facility admission agreements since 1987. Current DHS surveyor guidelines for assessing compliance contain the review of arbitration agreements that are contained in admission agreements.
Commenter: 896.2

Department Response:
As another Commenter noted, there has been a perceived history of questionable practices in skilled nursing facility admissions, which lead to the passage of SB

1061. That legislation was enacted to address admission practices, and provided the Department with authority to separate the Standard Admission Agreement from any arbitration agreement. Surveyor guidelines will duly reflect that requirement.

N. Comment: DHS lacks authority for proposed subsections (d) of 22CCR §72516 and §73518, and they should be deleted. The commenter provided suggested language. If an arbitration clause is not included in the Standard Admission Agreement, under what authority does the Department propose to implement its requirement in Section (d) for an "advisory in a prominent place in the arbitration agreement?" Commenter adds that HSC 1599.81 sets forth protections for use of an arbitration agreement, such as notice regarding waiver of ability to sue for *Patient's Rights violations.*
Commenters: 896.2, 896.7; 898.5

Department Response:
As noted in the Initial Statement of Reasons (page 4), the provision for a prominently placed advisory on an arbitration agreement implements the direction of HSC §1599.81(a), that residents be clearly notified (emphasis added) that agreement to arbitration is not a precondition for admission, and HSC §1599.81(d), which requires notice to residents that they may not waive the ability to sue for violation of the Resident Bill of Rights. In addition, HSC §123222.1 requires that admission papers and forms used by skilled nursing facilities and intermediate care facilities shall be printed in at least 12-point type that is clear and legible. The statutes are permissive in allowing the use of arbitration agreements; however their usage triggers the need for specific cautions that the Department is compelled to impose.

O. Comment: In support of their contention that arbitration agreements should be allowed during the admissions process, commenter challenges DHS' interpretation of HSC §1599.60, §1599.61, and §1599.81 and presented case laws (*Morris v. Williams* (1967) 67 Cal.2d 733, 737; *Henning v. Division of Occupational Saf. & Health* (1990) 219 Cal.App.3d 747, 759; *City of Santa Cruz v. Municipal Court (1989)* 49 Cal.3d 74, 90; *McRae v. Superior Court* (1963) 221 Cal.App.2d 166, 171; *Government Emp. Insulation Co. v. Brunner* (1961) 191 Cal.App.2d 334; *Vernon v. Drexel Burnham and Co., Inc.* (1975) 219[sic] 52 Cal.App.3d 747[sic] 322; and *Firestone Tire and Rubber Co. v. United Rubber Workers of America, Local Union No. 100* (1959) 168 Cal. App.2d 444). States that DHS' interpretation of the law as stated in the Initial Statement of Reasons is unlawful and DHS has no regulatory authority to alter the statutory requirement that facilities be allowed to include a binding arbitration clause in the Standard Admission Agreement if it chooses. DHS also does not have the authority to regulate arbitration agreements outside of the Standard Admission Agreement.
Commenters: 898.5, 907.1

Department Response:
The Department disagrees with the commenter's interpretation of case law cited, because it did not involve the Department of Health Services, did not interpret HSC

§1599.60, §1599.61, and §1599.81, and does not pertain to Department operations. Please also see responses to Comments 2.A and 2.C. The Department also disagrees with the comment, and asserts that it has been granted the authority under SB 1061 to separate the Standard Admission Agreement from the arbitration agreement for the reasons noted in responses to Comments 2.A, 2.C and 2.N.

P. Comment: Commenters state that Code of Civil Procedure §1295 "recognizes the need for arbitration in the healthcare context;" present similar arguments as in Comment 2.A and 2.C concerning interpretation of the Code of Civil Procedure, and the Legislature's intent re arbitration agreements. Recommends revised language.
Commenter: 898.5; 907.3

Department Response:
The Department disagrees with the interpretation of Code of Civil Procedure §1295, which specifies how arbitration should be used in medical services contracts, but does not require its use; DHS also disagrees with the commenter's recommended revisions.

Q. Comment: Placing the arbitration agreement in the Standard Admission Agreement provides an additional consumer protection by providing regulatory oversight. DHS only has authority for oversight of the Agreement.
Commenter: 898.5

Department Response:
DHS disagrees, because separating an arbitration agreement from the Standard Admission Agreement does not compromise any consumer protections provided by use of the arbitration agreement. The Department has followed statutory authority in separating the arbitration agreement from the Standard Admission Agreement. Consumer protection through regulatory oversight of the arbitration agreement already exists, under HSC §§1599.81(a) and 1599.81(d), and under §1295 of the Code of Civil Procedure.

R. Comment: No longer allowing arbitration clauses will not improve care in skilled nursing facilities, but will lead to more litigated claims going to court which will drive up insurance rates for providers.
Commenter: 900.1

Department Response:
The Department cannot respond to this assertion, because the commenter has provided no evidence to support the correlation between the presence or absence of arbitration agreements and the quality of care, quantity of litigation, and cost of provider insurance rates in skilled nursing facilities.

S. Comment: Residents need the opportunity to opt for arbitration. The Standard Admission Agreement precludes this option and limits residents' freedom of choice.
Commenters: 901.2, 914.2

Department Response:
Nothing in the regulation precludes a resident from having the opportunity to enter into an arbitration agreement with a facility.

T. Comment: This prohibition in the regulations attempts to single out and apply admission standards that are not found in any other level of healthcare in the State of California. Presumes arbitration provisions are inappropriate, wrong and should be seen in a negative light by requiring that such clauses may not be presented to prospective residents as part of a Standard Admission Agreement.
Commenter: 903.2, 903.3

Department Response:
The Department disagrees that the regulations prohibit arbitration, and has followed statutory authority in establishing a Standard Admission Agreement. DHS makes no presumptions regarding the efficacy of arbitration, but merely separates it from the Standard Admission Agreement in the regulations.

U. Comment: Commenter presents the same concerns as in Comments 2.A, 2.C, 2.E, and 2.O above. DHS apparently feels that, despite clear statutory language to the contrary, it must extend its regulatory arm to assure that agreements to arbitrate be separated from, and not combined with or made a part of, admission agreements. Consumers are, in its view, too powerless or incapable of reading and understanding an arbitration clause in an admissions agreement even when it is printed consistent with state law requirements to assure adequate notice to them.
Commenter: 907.5

Department Response:
DHS disagrees with these comments, for the reasons noted in responses to Comments 2.A, 2.C, 2.E, and 2.O. The content of the Standard Admission Agreement constitutes no comment by the Department regarding consumers' cognitive capabilities.

V. Comment: DHS' reasoning in support of the proposed "separation" regulation turns logic on its head; it essentially tries to redefine "permissive combination" to mean "mandatory separation" in violation of HSC §1599.81's plain meaning. Under state law, administrative agencies have only such powers as have been conferred on them, expressly or by implication, by constitution or statute (*Fredig v. State Personnel Board*, 71 Cal.2nd 96 (1969)).
Commenter: 907.2

Department Response:
The Department disagrees, and believes that an arbitration agreement, if considered, shall be negotiated separately from the Standard Admission Agreement, for the reasons previously cited in Comment 2.A. HSC §1599.81 need not be repealed in order to mandate the separation of the agreements called for under HSC §1599.61, and the latter statute conferred sufficient authority to issue these

regulations. The case law cited did not involve the Department of Health Services, did not interpret HSC §1599.61 and §1599.81, and does not pertain to Department operations.

W. Comment: Arbitration is allowed in admission agreements in accordance with HSC §1599.81. Proposed regulations will prohibit this. Will the Health and Safety Code be amended? Can an arbitration agreement be used along with the new Standard Admission Agreement?
Commenter: 915.2

Department Response:
See response to Comment 2.V. The Department disagrees arbitration is prohibited in the proposed regulations: per §72516(c) and §73518 (c), "No resident or his or her legal representative shall be required to sign any other document at the time of, or as a condition of, admission to the licensee's facility, or as a condition of continued stay in the facility."

X. Comment: Suggests that the Standard Admission Agreement should better distinguish that the arbitration agreements are not required "as a condition of admission".
Commenter: PH 1.2

Department Response:
DHS does not agree with the need for additional emphasis of this provision, which is prominently addressed on page 1 of the Standard Admission Agreement by the following language:
"You shall not be required to sign any other document at the time of, or as a condition of, admission to this Facility."

Y. Comment: The arbitration agreement should be separate from the Standard Admission Agreement. Written and oral testimony strongly argue that residents must clearly understand that an agreement to arbitrate is not required as a condition of admission; hence arbitration agreements should be separate from the Standard Admission Agreement. Further comments state that residents often sign arbitration agreements because they believe that it is routine, or because they feel that a refusal to sign will jeopardize the admission, and that residents and their representatives should be asked to sign nothing of a contractual nature other than the Standard Admission Agreement during the admission process.

Commenters further state that nothing in HSC §1599.61 mandates that arbitration attachments are allowed, and because a later-enacted statute prevails in the interpretation of conflicting statutes, any condoning of arbitration attachments in HSC §1599.81 is overridden by the 1997 statute requiring that skilled nursing and intermediate care facilities use a Standard Admission Agreement that protects residents' rights.
Commenters: 894.2; 895.2; PH 1.2; PH 5.7

Department Response:
The Department concurs that any arbitration agreement shall be separate from the Standard Admission Agreement. The proposed regulations do not place an outright prohibition on the use of arbitration agreements, provided they are not required as a precondition for admission or continued stay in a facility.

3. 22CCR §72516(c) and §73518(c) - Freedom to Contract:
No resident or his or her legal representative shall be required to sign any other document at the time of, or as a condition of, admission to the licensee's facility, or as a condition of continued stay in the facility.
A. Comment: The Department has arbitrarily and broadly restricted the facility's freedom to contract (Initial Statement of Reasons, page 2, and §72516(b) and §73518(b)). There are many other legal documents that a patient signs at the time of admission and now it is unclear whether or not this information will be construed as another contract of admission. Commenters state that the prohibition in the proposed regulations that "...the licensee shall not alter the Standard Admission Agreement without the prior written authorization of the Department" is arbitrary and represents "an unconstitutional abridgement of the freedom of contract."
Commenters: 3.1; 27.1; 31.1; 34.1-46.1; 160B.1-199.1; 222.1-281.1; 391.1-438.1; 493.1-499.1; 889.3; 890.1; 896.3; 898.7; 900.2; 901.1; 907.2; 911.4; 913.1; 914.1; 915.1; PH 4.4

Department Response:
The Department disagrees with comments that the Standard Admission Agreement is arbitrary, or that it abridges a facility's "freedom of contract," for a number of reasons. SB 1061 clearly "mandate[s] a Standard Admission Agreement to be used for all admissions to skilled nursing facilities, intermediate care facilities, and nursing facilities in California." The law also mandated that "no facility shall alter the standard agreement unless so directed by the Department," and required that the Agreement comply with all applicable state and federal laws.

Furthermore, Article 3, Section 3.5 of the California Constitution provides that "An administrative agency, including an administrative agency created by the Constitution or an initiative statute, has no power:
(a) To declare a statute unenforceable, or refuse to enforce a statute, on the basis of it being unconstitutional unless an appellate court has made a determination that such statute is unconstitutional;
(b) To declare a statute unconstitutional;
(c) To declare a statute unenforceable, or to refuse to enforce a statute on the basis that federal law or federal regulations prohibit the enforcement of such statute unless an appellate court has made a determination that the enforcement of such statute is prohibited by federal law or federal regulations."

B. Comment: Conversely, another commenter disputes the validity of Constitutional arguments supporting a facility's "right to contract," and cites legal

precedents supporting the Department's authority to regulate licensed skilled nursing or intermediate care facilities, and to require a Standard Admission Agreement.
Commenter: 894.17

Department Response:
The Department acknowledges the comment – please see Comment 3.A.

C. Comment: Facilities may have other contractual relationships with the resident that impacts the admission process. Many of CAHSA's skilled nursing facilities are part of a Continuing Care Retirement Community and as such have their own statutory provisions concerning contracts for entering the community. Nothing in the enabling legislation set forth at HSC §1599.61 prohibits the skilled nursing facility from having other contracts.
Commenter: 896.6

Department Response:
DHS agrees that facilities are not precluded from entering into other agreements; per HSC §1599.61(b)(3), "Nothing in this section shall prevent a skilled nursing facility, an intermediate care facility, or a nursing facility from distributing written explanations of facility-specific rules and procedures, provided that the written explanations are not included or incorporated in, or attached to the Standard Admission Agreement, nor signed by the resident or his or her representative."

As the Commenter notes, facilities may have other contractual relationships with residents in support of their daily care. Facility-specific rules, procedures and other matters of a resident's care may be presented and resolved, provided they are not included in the Standard Admission Agreement or presented as a condition of admission or continued stay in the facility.

D. Comment: Opposes the following language: "No resident or his or her legal representative shall be required to sign any other document at the time of admission..." because there are several other documents at the time of admission that require signature; recommends language be deleted. If an individual takes 22CCR §72516(c) literally, an individual may refuse to sign any other documents at admission. There are a number of documents that facilities present at or upon admission that require signature by the patient, agent or responsible party. Although these other documents are not a part of the admission agreement, they are a part of the admission process. The Department has incorrectly paraphrased the definition of "contract of admission" in HSC §1599.60(b), which will confuse consumers and will complicate the admission process for facilities. Suggested that the Department clarify in the Agreement that there may be other documents presented by the facility as part of the admission process requiring the patient's signature.
Commenters: 896.6; 904.2

Department Response:
The Department disagrees; see responses to Comments 3.A and 3.C (above).

E. Comment: Objects to the inclusion of the phrase "as a condition of continued stay in the facility" in the regulations. By adding this interpretation, the language is confusing and inconsistent; the regulation should accurately reflect HSC 1599.60(b).
Commenters: 896.6

Department Response:
The Department disagrees, and believes that the rationale for this regulatory language is clearly explained in Subsection (c) of the Initial Statement of Reasons. This language is consistent with HSC §1599.60(b) which defines a contract of admission as including all documents which must be signed by the resident or his or her representative at the time of, or as a condition of, admission. This protects residents against the possibility that documents other than the Standard Admission Agreement might be represented to them as documents that require their signature at any time (emphasis added) as a condition of admission or remaining in the facility.

F. Comment: DHS acknowledges in its Initial Statement of Reasons that the law "does not preclude facilities from discussing other documents (such as selection of a pharmacy), and presenting those documents to prospective residents for their voluntary signature, as long as those documents are clearly separate from the admission agreement and are not presented as a condition of admission." Based upon a plain reading of the statement, it appears that a licensee does not have to wait any period of time, other than the amount of time it would take to present additional information and answer questions, between the signing of the Standard Admission Agreement and the presentation of other documents for signature. Is this an accurate interpretation of this statement? Gives examples of other information presented to a resident during the admission process.
Commenter: 898.4

Department Response:
In the Initial Statement of Reasons, the Department acknowledges that other documents (such as selection of a pharmacy) may be discussed following a resident's admission to a facility. The commenter lists other information that may be reviewed following admission, including Medi-Cal eligibility, privacy notices, physician designation, and information on advance directives (among others). These and other documents are legitimate items for discussion, so long as they are brought up separately following admission, and it is clear to the prospective resident that no document other than the Standard Admission Agreement shall be signed as a condition of admission or continued stay in the facility.

G. Comment: Facility claims that a "right to contract" limits the Department's ability to require use of a Standard Admission Agreement are specious arguments. Based upon several U.S. Supreme Court cases, there is no legal basis for any supposed right to contract. The Department has authority to require a Standard Admission Agreement, for the same reasons that the Department has authority to regulate the care provided to nursing facility residents.
Commenter: 894.17

Department Response:
The Department agrees that a Standard Admission Agreement is required by statute. Please refer to response to Comment 3.A.

4. Program Flexibility: Facilities may not alter the Standard Admission Agreement without prior approval from DHS.
A. Comment: Some commenters state that the regulations do not outline what "program flexibility" means with respect to what terms and/or conditions will be permitted in the Standard Admission Agreement, or specify what standards will be used by the Department of Health Services in approving a program flex, or the procedure for appeals. There are also comments relating to the timing and implementation of flex submissions, and how the Department will handle a large volume of requests for contract alterations. Many commenters submit proposed language changes related to applying for Medi-Cal, non-discrimination, responsibility for co-payments, assignment of Social Security checks, etc. Finally, as noted elsewhere, inclusion of an arbitration agreement with the Standard Admission Agreement is the most commonly cited example of this regulatory restriction.
Commenters: 4.2; 6.2; 9.2; 10.2; 12.2; 14.1; 15.2; 16.2; 17.1; 21.2; 24.1; 26.1; 27.2; 31.1; 32.2; 160B.2-390.2; 391.1-438.1; 890.2; 896.5; 898.2; 911.4; 912.2; 913.1; PH 2.6; PH 4.5

Department Response:
The Department does not agree with the need to reiterate the definition of or procedures for obtaining program flexibility in these regulations, or the need to place them in the Standard Admission Agreement. Requests for inclusion of alternative contract language in the Standard Admission Agreement cannot be considered because of the lack of statutory authority.

However, the statute itself [HSC §1599.61(b)(1)] provides that a facility may alter the Agreement if "so directed by the [D]epartment," and proposed regulations §72516/73518(b) permit altering the Standard Admission Agreement, with prior written authorization. Additionally, program flexibility requirements are delineated in California statutes for licensed health facilities. Facilities are permitted, under HSC §1276(b), (c), and (d), to apply for program flexibility they believe to be appropriate for the operation of their facility.

B. Comment: Notes the case of SNF-STPs (Skilled Nursing Facilities with Special Treatment Programs) that provide mental health services to patients involuntarily admitted by court-appointed conservators, which will require extensive modifications to the Standard Admission Agreement. The Agreement needs to address the special treatment needs of their unique service settings. A commenter also includes a list of informational items presented to residents with an Admission Agreement as part of the admissions process, adding that, under the Preamble and Title 22 §72516(c), it is not clear whether these will be permitted.
Commenters: 904.1; 904.2; 904.4

Department Response:
As previously noted, the Department has not been granted the statutory authority to exempt any licensed skilled nursing facilities, intermediate care facilities, or nursing facilities from the requirement to use a Standard Admission Agreement. Such facilities must use program flex provisions under HSC §1276 et seq. in order to address their particular facility needs with regard to the Agreement.

C. Comment: Public testimony indicated that inclusion of additional business terms in the Standard Admission Agreement would subvert the intent of the legislation and undermine the protections of the Agreement.
Commenter: PH 5.8

Department Response:
DHS agrees that facilities shall not alter the Standard Admission Agreement, for reasons discussed in Comments 4.A and 4.B. It should be noted that the Department, in response to comments, has revised the Agreement to add certain commonly used contract terminology; please see Comment 24.C. In addition, under HSC §123222.2(2)(B), "[A] facility may also provide written materials regarding the facility's expectations of patients' [residents'] responsibilities while the patient [resident] is receiving care at the facility." This must be provided separately from the Agreement.

D. Comment: Language should be added at the end of the Preamble that states that the Standard Admission Agreement cannot be modified by an employee or agent of the facility; includes suggested language.
Commenter: 898.11

Department Response:
The Department disagrees with the need for this addition to the Standard Admission Agreement, since it is clearly stated in the text of proposed regulations 22CCR §72516(b) and §73518(b).

E. Comment: Suggest non-discrimination clause be added to language of the Standard Admission Agreement; includes suggested language.
Commenters: 392.2-438.2

Department Response:
The Department disagrees with the need for this addition to the Standard Admission Agreement, because residents are adequately protected against discrimination by the Resident Bill of Rights and other Agreement language prohibiting discrimination based on source of payments.

F. Comment: Much of the language of the Agreement discusses Medicare; Commenter requests ability to change it for non-Medicare facilities.
Commenter: 914.1

Department Response:
As noted in Comment 4.A, facilities are permitted, under HSC §1276(b), (c), and (d), to apply for program flexibility to request modifications to the Standard Admission Agreement that they believe to be appropriate for the operation of their facility.

5. The Standard Admission Agreement should be placed in regulations.
A. Comment: Some object to inclusion of the Standard Admission Agreement in proposed regulation through incorporation by reference, stating that it is neither a statute nor a form within the meaning of the Administrative Procedures Act, but contains prescriptive contractual mandates. Commenters note that it is unclear what the mechanism will be for public notification of future changes to the form, and request that the Standard Admission Agreement be included in regulations, rather than incorporated by reference. Another commenter maintains that DHS granted their petition for adoption of the Standard Admission Agreement by regulation, on January 12, 2000, and states that the law requires that the Department shall promulgate the Standard Admission Agreement "in its totality" by regulation. Another commenter claims that the Standard Admission Agreement is not "linked" to the regulations.
Commenters: 889.4; 896.4, 896.8; 898.1; 901.3; 913.3; 915.3; PH 4.6

Department Response:
As stated in the Initial Statement of Reasons (page 2), the Department has provided its rationale for inclusion of the Standard Admission Agreement through incorporation by reference. DHS has determined that it will be more efficient and effective to incorporate the standard form by reference, rather than adopting regulations describing the standard form. By incorporating the form by reference, the Department can make it available more universally for use by licensees.
The Department has followed the requirements of the Administrative Procedures Act in utilizing incorporation by reference. This represents a legitimate form of regulation, according to Government Code §11344.6, which provides that "The courts shall take judicial notice of the contents of each regulations which is printed or which is incorporated by appropriate reference into the California Code of Regulations as compiled by the [Office of Administrative Law]. Further, case law states that the "Practice of incorporating by reference in published regulations... does not facially violate Administrative Procedure Act (APA), even though no statute explicitly authorizes practice of incorporation by reference... in light of Office of Administrative Law (OAL) regulation expressly approving general practice, existence of Government Code provision assuming practice is lawful, and OAL's oversight of use of practice (*Kings Rehabilitation Center, Inc. v. Premo* (App.3 Dist. 1999) 81 Cal.Rptr.2d 406, 69 Cal.App.4th 215, 217).

Any future changes of the form that are necessary will be subject to the approval of the OAL, in conformance with the requirements of Government Code §11340 et seq.

B. Comment: DHS has failed to follow basic rules in promulgating the regulations. A commenter states in written and oral testimony that DHS did not conform to the APA in drafting the proposed regulations, and specifically that there are provisions in the Agreement that lack any statutory authority, utilize federal authority that has not been adopted by the state, are contrary to statutory authority, and change the intent and meaning of the enabling legislation. The commenter cites as examples of this the Department's inconsistent use of 1987 provisions of HSC §1599.60, the transfer and discharge provisions of the Standard Admission Agreement, and the use of a patient rights education pamphlet as a Patient Rights attachment to the Standard Admission Agreement.
Commenter: 889.4; PH 4.7

Department Response:
See previous response. The Department disagrees with this comment, and has conformed with all state and federal statutory authority in drafting these regulations. The intent and meaning of SB 1061 is quite clear, and the Department has complied with that. Commenters' specific examples of inconsistent application of statutes are addressed elsewhere in this document (please see Comments 2.A, 9.A, and 10.A).

C. Comment: It is unclear how to interpret the contract, because it is not linked to regulations.
Commenter: 901.3

Department Response:
The Department disagrees, and believes that the Standard Admission Agreement is properly placed in regulations and is sufficiently clear; please see responses to Comments 5.A and 5.B.

6. Citations/Reports of State Inspections.
A. Comment: Object to inclusion of the following Preamble language regarding posting of §2567 citations: "Reports of state inspections of our Facility are posted here at the Facility, and a copy may be obtained from the local office of the California Department of Health Services (DHS), Licensing and Certification Division." They do not believe that this language should be a standard for an admission agreement, since HSC §1599.87 requires that only those 25 percent of long-term care facilities with the most serious records of violations of laws or regulations shall include the language in their admission agreements, and not the other 75 percent. Commenters state that it is inappropriate to include this language in a Standard Admission Agreement.
Commenters: 5, 11, 18, 23, 30; 439-491; 892; 898.10

Department Response:
In the Initial Statement of Reasons Preamble the Department explained its rationale for using a stricter reporting standard than that of HSC §1599.87, which predates the mandate in SB 1061 for a uniform Standard Admission Agreement that complies

with all applicable state and federal laws, and is to be used by all licensed facilities in California.

In addition to the reporting requirements cited from the Health and Safety Code, this regulation is consistent with the requirements of 22CCR §72503, which requires "conspicuous post[ing] in a prominent location accessible to the public" of the most recent licensing visit report, as well as with 42CFR §483.10(g)(1), which states (regarding examination of survey results), "The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability." This federal standard is also stated in the Resident Bill of Rights, Attachment A of the Agreement.

Finally, DHS has revised the Agreement (page 1 of the post-hearing document) to allow a facility to insert information about its posting of state inspection reports.

B. Comment: A request that the notification in Section IV of the Agreement (Your Rights as a Resident) be revised as follows: "~~Willful or repeated~~ violations of state laws identified above may subject our Facility and our staff to civil or criminal proceedings." They cite as a rationale for the change that a single violation may justify liability, under HSC §1424 and various federal provisions.
Commenters: 894.5; 897.2

Department Response:
The Department agrees, and has made the recommended change to the Agreement (page 4 of the post-hearing document). Notwithstanding the requirements of HSC §1599.2 (Attachment A) to include this notification when informing residents of their rights, DHS has adhered to HSC §1424 in including a more stringent standard regarding violations of state laws and regulations. (Please also refer to the response to Comment 9.S for a related discussion of this section.)

7. Consent to Treatment/Advance Directives.
A. Comment: The language in the Initial Statement of Reasons (page 9) and Consent to Treatment section related to Advance Directives inappropriately states that Residents should "...inform our staff so that we may ensure your wishes are respected." They note that under §4734 of the Probate Code, a facility may decline to comply with an individual healthcare instruction if the instruction is contrary to a policy of the institution that is expressly based on reasons of conscience, or, under §4735, that requires medically ineffective healthcare or is contrary to generally accepted healthcare standards. They add that inclusion of the new regulatory standard would encourage liability based on breach of contract theory.
Commenters: 34.1; 36.1; 39.1; 42.1; 43.1; 47.1; 653.1-711.1; 898.14; 908.3; 909.4; 911.7

Department Response:
DHS agrees that residents should be appropriately informed of their rights concerning Advance Directives, and has revised the Agreement (pp. 3-4 of the post-hearing document) to address these comments.

B. Comment: Asks that Section III of the Agreement (Consent to Treatment) include a reference to the state-designated document required under the federal Patient Self-Determination Act (42CFR 483.10(b)(8)). Recommends adding to the section: "Additional information about healthcare decision-making is available from [the state-designated document], which is distributed with this Agreement."
Commenter: 894.4

Department Response:
The Department believes that it is unnecessary to include the requested document with the Standard Admission Agreement. Residents in licensed-only (non-Medi-Cal) facilities are sufficiently informed of their rights with regard to Consent to Treatment under state statutes, including HSC §1599.73, which encourages them, after admission, to complete an advance health care directive. In addition, certified facilities are separately held to the federal requirement under 42CFR 483.10(b)(8), to inform residents of their rights in this regard. This federal standard is also stated in the Resident Bill of Rights, Attachment A of the Agreement.

C. Comment: States that Section III is confusing and awkward, because 22CCR §72527 and §72528 clearly place responsibility for informed consent with resident's physician, not the facility. They request that this section be rewritten.
Commenter: 896.11

Department Response:
The Agreement has been revised (page 5 of the post-hearing document) to encourage residents to complete an Advance Directive, in conformance with state and federal requirements; DHS believes the revision addresses this concern.

D. Comment: §4677 of the Probate Code prohibits a licensee from requiring or prohibiting the execution of an advance directive as a condition for admission to a facility, while HSC §1599.73 encourages residents having capacity to execute an advance directive. The commenter requests that Agreement language be amended to maintain consistency with current law, and that advance directive information be given to the resident at the time of admission, then further discussed with the resident and his or her physician. They also note Probate Code §4675, which requires that any resident who executes and advance directive in a skilled nursing facility to have an ombudsman witness its execution.
Commenter: 910.2

Department Response:
As noted, the Department has revised Consent to Treatment provisions; however, DHS does not agree that restatement of ombudsman responsibilities already in

statute is necessary, and its inclusion would overburden the language of the Standard Admission Agreement.

8. Consent to Treatment: "Medical Care."

A. Comment: The following Agreement language cited at page 9 of the Initial Statement of Reasons is inappropriate and should be eliminated: "We will keep you informed about nursing care and medical care we provide to you, and we will answer your questions about the care and services we provide you." Commenters state that the Department has misinterpreted Title 22, §72527(a)(5), which cites a resident's right "to receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure." Another adds that "to the extent permitted by law" should be added to the provision for refusal of medical treatment.
Commenters: 492-523; 904.3; 910.1

Department Response:
The Department agrees with the comment, and has revised the language of the Standard Admission Agreement (p. 3 of the post-hearing document) to conform with statutory requirements regarding consent to treatment, as cited in HSC §1599.72 and 22CCR §72527(a).

B. Comment: 22CCR §72528(g) specifically states that any "general consent provision in a contract for admission shall only encompass consent for routine nursing or emergency care." Commenters state that inclusion of Initial Statement of Reasons language (page 9) requiring a facility to keep the patient informed of "medical care" is an inappropriate contract term that encourages additional liability on the facility's part.
Commenters: 896.11; 898.14

Department Response:
See Comment 8.A. The language related to provisions for care in the Financial Arrangements section of the Agreement (page 5 of the post-hearing document) has also been revised to conform with HSC §1579.72 and 22CCR §72527(g). The Department believes that the revision addresses these concerns.

C. Comment: The Agreement should include a provision stating that the facility shall provide for nursing services consistent with relevant state and federal law.
Commenter: PH 5.5

Department Response:
The Department does not agree that the suggested revision is required, because provisions for nursing services are the general consideration of the Standard Admission Agreement as a whole, and are specifically addressed in Consent to Treatment and Financial Arrangements sections. See previous response.

9. Residents' Bill of Rights (Attachment A and Section IV.)
A. Comment: The summary of Residents' Rights is not a comprehensive list, and a number of rights need clarification. DHS has no authority to summarize residents' rights, which in several instances, has changed the actual meaning of the statute and/or regulation, and has created confusion and misunderstanding. Suggest using exact wording of regulations.
Commenters: 40.1; 48.1; 50.1; 51.1; 712.1-888.1; 894.15; 895.3; 896.12, 896.19; 897.6; 898.15; 899; 900.3; 902.2; 905.2; 908.1; 909.3; 911.8, 911.15; 913.4; 915.4; PH 1.4

Department Response: The Department acknowledges this concern, and has elected to revise the Resident Bill of Rights (Attachment A to the Agreement), consistent with the mandates of SB 1061, to reflect Resident Rights as stated in 22CCR §§72527 and 73523, HSC §1599 et seq., and 42CFR 483.10, 42CFR 483.12, 42CFR 483.13, and 42CFR 483.15.

[It should be noted that in its15-day post-hearing change availability the Department did not attach resident's rights specified in 42CFR 483.12, 483.13, and 483.15, which are referenced by or directly refer to resident rights under federal regulations. Following further review, DHS has elected to include these rights in Attachment A of the Standard Admission Agreement, in accordance with the mandates of HSC §1599.61(d). DHS makes this change to the text of the regulations, which is deemed to be non-substantive and without regulatory effect, pursuant to 1CCR 100(a)(6), and which is not subject to the rule-making process as specified in Article 5 of the Administrative Procedures Act.]

B. Comment: States that #13 in Resident's Bill of Rights is inaccurate because it is missing an essential phrase, "as authorized by law," which should be added. Without the phrase, it may be implied that residents will have an ability to deny access by anyone, other than facility staff, to their medical and financial records.
Commenters: 40.2; 760.2-774.2; 827.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and 22CCR §72527(a)(10).

C. Comment: States that #20 in Resident's Bill of Rights is inaccurate because it does state that residents can be transferred for the reasons specified in CFR 483.12.
Commenters: 810.2-826.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and 42CFR 483.10(10)(D) and 483.12(a) and (b).

D. Comment: States that #21 in Resident's Bill of Rights is inaccurate as stated, and should state that a facility shall not be required to maintain a bed-hold for more than seven days, and that the resident is liable to pay the facility's daily rate for any bed-hold days.

Commenters: 50.2; 828.2-842.2; 898.15

Department Response:
The Department has addressed this concern; see response to comment 9.A, and 42CFR 483.10(10)(D) and 483.12(a) and (b).

E. Comment: States that #12 in Resident's Bill of Rights is inaccurate because HSC 1599.1(g)(2) states that a facility is not required to disclose ownership interests if the resident is covered by an HMO.
Commenters: 51.2; 747.2-759.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and 22CCR §72527(a)(22), HSC §1599.1(g)(1), and HSC §1323.

F. Comment: States that #6 in Resident's Bill of Rights is inaccurate because under 22 CCR §72527(a), a resident may, and often is, responsible for paying his or her share of cost for services provided by the Medi-Cal program.
Commenters: 728.2-746.2; 898.15; 909.3

Department Response: The Department has addressed this concern; please refer to responses to comments 9.A and 12.A, and 22CCR §72527(a)(2).

G. Comment: States that #15 in Resident's Bill of Rights is inaccurate because it omits essential items per HSC §1599.1(a) & (b), which requires the "enough staff" to include business office personnel, laundry, housekeeping, janitorial, building grounds staff, and other staff that are necessary to meet facility operational needs. In addition, the proposed language implies that residents will under no circumstances develop bedsores or become incontinent.
Commenters: 48.2; 775.2-791.2; 898.15; PH 2.9

Department Response: The Department has addressed this concern; see response to comment 9.A, and HSC §1599.1(a) and (b).

H. Comment: States that #16 in Resident's Bill of Rights is inaccurate because the term "good" food is subjective. HSC §1599.1(c) states that the facility shall provide food of the "quality" and "quantity" to meet the patient's needs in accordance with physician's orders.
Commenters: 792.2-809.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and HSC §1599.1(c).

I. Comment: State that #22 in Resident's Bill of Rights is inaccurate because it does not exactly reflect 22CCR §72527(a)(15) states regarding personal items.
Commenters: 843.2-864.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and 22CCR §72527(a)(15).

J. Comment: States that #25 in Resident's Bill of Rights is inaccurate because it does not exactly reflect 22CCR §72527(a)(18) and (19), which delineate visitation rights.
Commenters: 865.2-877.2; 898.15

Department Response: The Department has addressed this concern; see response to comment 9.A, and 22CCR §72527(a)(18) and (19).

K. Comment: States that #31 in Resident's Bill of Rights is inaccurate because it should include the words "services provide [*sic*] in the facility." By leaving these words out, the resident has no reasonable expectation of what the facility is required to make accommodation for. It also leaves out the reference to prohibiting an accommodation if it poses a danger to the "resident."
Commenters: 878.2-888.2; 898.15

Department Response: Department Response: The Department has addressed this concern; see response to comment 9.A, and 42CFR 483.15(e).

L. Comment: States that the Resident's Bill of Rights has omitted the right to "receive notice before the resident's room or roommate in the facility is changed," as stated in CFR 483.15(e)(2).
Commenters: 878.3-888.3; 894.15; 898.15

Department Response: Department Response: The Department has addressed this concern; see response to comment 9.A, and 42CFR 483.15(e).

M. Comment: States that #1 in the Resident's Bill of Rights should include the words "the right to be fully informed in a language you understand."
Commenter: 894.15; 895.3

Department Response: The Department has addressed this concern; see response to comment 9.A, and 22CCR §72527(a)(1) and 42CFR 483.10(b)(1).

N. Comment: States that #5 in the Resident's Bill of Rights omits the reference of HSC §1418.2 through §1418.4 regarding resident councils and family groups.
Commenter: 894.15; 895.3

Department Response: The Department has addressed this concern; see response to comment 9.A and 42CFR 483.15(c).

O. Comment: States that #23 in the Resident's Bill of Rights omits 22CCR §72529, which states, "If you entrust money to the facility, the right to withdraw funds within a

reasonable period of time and to receive a quarterly account statement." This should be added.
Commenter: 894.15; 895.3

Department Response: The Department has addressed this concern; see comment 9.A and 22CCR §72527(a)(8), §72529, and 42CFR 483.10(c)(1).

P. Comment: Requests that the Resident's Bill of Rights include information for the resident concerning what the facility would provide or require of the resident in case of disaster or emergency evacuation.
Commenter: 899

Department Response: The Department acknowledges this concern, but believes this type of facility-specific information should be provided separately from the Standard Admission Agreement. Also, disaster planning for healthcare facilities is sufficiently addressed under 42CFR 483.75(m) and 483.470(h), and Health and Safety Code §1336.3(b).

Q. Comment: State that the Residents' Bill of Rights is missing several rights, which should be added:

- The right to privacy in care and treatment. [22CCR §72527(a)(11), 42CFR 843.10(e)(1)]
- The right to equal treatment and care regardless of source of payment. [42CFR 483.12(c)]
- The right to make reasonable choices about your daily life, including choices about schedules, services and activities. [42CFR 483.15(b)]
- The right to written and oral information about how to apply for and use Medicare and Medi-Cal benefits from facilities that participate in these programs. A facility certified for Medi-Cal cannot require you to remain in private pay status for any period of time prior to converting to Medi-Cal coverage. [HSC §1599.69, 42CFR 483.10(b)(10) and 483.12(d)]
- The right to not be moved from one room to another solely because one room is certified for Medicare or Medi-Cal, and the other room is not. [42CFR 483.10(o)]
- The right to at least a 30-day written notice prior to an increase in the daily room rate or to the charges assessed for other services. (HSC §1599.67(c)]
- The right to reimbursement for personal property that is lost or stolen if the facility had failed to make reasonable efforts to protect that property. [HSC §1289.3]
- The right to purchase drugs, or rent or purchase medical supplies, from a pharmacy or provider of your choice, subject to certain limitations. [HSC §1320, 22CCR §72527(a)(22), 42CFR 483.10(c)]
- The right to self-administer medications if it is safe to do so. [42CFR 483.10(n)]

Commenters: 894.15; 895.3; 897.6; 902.2

Department Response: The Department acknowledges this concern, and has elected to revise the Resident Bill of Rights, consistent with the mandates of SB

1061, to reflect Resident Rights stated in 22CCR §§72527 and 73523, HSC §1599 et seq., and 42CFR 483.10, 42CFR 483.12, 42CFR 483.13, and 42CFR 483.15.

R. Comment: Your Rights as a Resident. The words "and liberties" should be removed from the sentence since they are potentially confusing; suggests rewording to be "You have the right to safely tell us about any problems you experience. You may submit any complaints, questions, or concerns about our services or your rights to the local office of the DHS licensing and Certification Division."
Commenter: 911.8

Department Response: The Department agrees that this language is potentially confusing, and has revised the Resident Bill of Rights (Attachment A to the Agreement) as directed by SB 1061 to exactly reflect Resident Rights as stated in 22CCR §§72527 and 73523, HSC §1599 et seq., and 42CFR 483.10, 42CFR 483.12, 42CFR 483.13, and 42CFR 483.15.

S. Comment: Your Rights as a Resident. Resident Rights provisions are not required in the body of the Standard Admission Agreement and should be removed, because they contradict current law and are inflammatory and offensive.
Commenter: 898.15

Department Response: The Department does not agree that this language should be eliminated from the Standard Admission Agreement, because it is taken directly from the Preamble of HSC §1599.2, a notification that is required by statute to be included in substance in the Agreement. In addition, SB 1061 requires that the Resident Bill of Rights be a mandatory attachment to all admission contracts, which necessitates its notice in the body of the Agreement, and this language is written in a manner to be consistent with HSC §1599.2.

10. Transfer and Discharge
A. Comment: Misrepresentation of finances is not a justification for transfer/ discharge allowed under federal law and should be eliminated. State law cannot take away a protection established by the federal nursing facility law. This is a rule established by the Supremacy Clause of the U.S. Constitution. Additionally, federal law (42CFR 483.12(a)(2)) already allows transfer/discharge for nonpayment.
Commenter: 894.9; 895.4; PH 1.5; PH 5.4

Department Response:
In its review of comments on the public notice the Department agreed with this comment, and removed misrepresentation of finances as a justification for involuntary transfer/discharge from the proposed regulations, as made available for 15-day review. In making this revision to the Standard Admission Agreement, DHS relied upon the standard extant in federal regulations (42CFR 483.12(a)(2)), rather than that cited in HSC §1439.7, because the federal standard pertains for the vast majority of nursing home residents, and provides for greater resident protections

afforded under federal law, in conformance with the intent of the enabling legislation. The state standard cited in HSC §1439.7 provides for conditions under which involuntary transfers from Medi-Cal participating facilities may be justified based on misrepresentation of finances.

After further consideration, the Department subsequently reinserted misrepresentation of finances as a valid justification for involuntary transfer /discharge. Despite the fact that state law cannot take away a protection granted by federal law, at the time of this rulemaking the federal standard has not been incorporated into California statute, nor prevailed in court over state law.

Additionally, HSC §1599.76 states "No contract of admission shall list any ground for involuntary transfer or discharge of the resident except those grounds which are specifically enumerated in either federal or state law." However, the Department concludes that it is required to enforce the standards in state law, per Section 3.5, Article 3 of the Constitution (please see response to Comment 3.A).

[Please refer to page 26 of the Final Statement of Reasons for further discussion.]

B. Comment: Misrepresentation of finances is a justification for involuntary discharge under HSC §§1599.76 and 1439.7, and should remain in the proposed Agreement.
Commenter: 906

Department Response:
Upon review, the Department agrees that this justification for involuntary discharge, as enumerated under state law, is required to be included in the Standard Admission Agreement. Please also see response to Comment 10.A.

C. Comment: Transfers cannot be based on a pending application for Medi-Cal, per WIC §14124.7(a); requests additional language be inserted in the Agreement.
Commenter: 894.10

Department Response:
The Department disagrees with the need for the revision, because residents are sufficiently protected from involuntary transfers under current state and federal laws and regulations.

D. Comment: States that this section is not clear about when a resident can be transferred from room to room because the Agreement misstates 42CFR 483.12(a)(1), which states that a transfer means from one certified facility to another. The misstatement in the Agreement allows the facility to transfer residents from one room to another at any time; recommends deletion of this language.
Commenter: 896.14

Department Response:
While the comment accurately paraphrases 42CFR 483.12(a)(1), the Department disagrees that residents may be transferred from one room to another at any time. WIC §14124.7 defines specific conditions under which may transfer a resident within a facility, and in addition to federal requirements, HSC §1599.78 requires that "no resident may be involuntarily transferred within or discharged from a long-term healthcare facility unless he or she is given reasonable notice in writing and transfer or discharge planning as required by law." As a basis of their licensure, facilities are held to state as well as to federal requirements in this area.

E. Comment: States that WIC §14124.7(c) allows a facility to transfer a resident within a facility because of a change in resident's healthcare needs or if the bed retention would result in no available Medicare-designated beds within a facility. Therefore, the prohibition against that in the Agreement should be eliminated. Also, clarification is needed regarding Medicare/Medi-Cal transfer rights.
Commenters: 896.14, 898.21, 911.14

Department Response:
DHS agrees with the comment, and has made the requested deletion from the Standard Admission Agreement (page 13 of the post-hearing document). Also, DHS reordered Agreement language to more clearly delineate between the allowable reasons for involuntary transfer or discharge, and the notice requirements entailed by such a transfer or discharge (pp. 12-13 of the post-hearing document).

F. Comment: States that the Agreement should identify the importance of discharge planning for voluntary discharges, citing 22CCR §72433(b)(5).
Commenters: 898.21

Department Response:
The cited regulation describes SNF Social Work Services Unit responsibilities; DHS disagrees with the need to include this level of detail in the Agreement.

G. Comment: The 30-day notice requirement is a misstatement of federal law 42CFR 483.12, and states that there are only two circumstances when a 30-day notice is required: 1) failure to pay, and 2) when a facility ceases to operate.
Commenters: 810-826; 898.21

Department Response:
DHS disagrees that the 30-day notice requirements cited in federal regulations are misstated in the Agreement. In fact, notification provisions in the Agreement conform with the federal requirements cited by the Commenter for circumstances when 30-day notification is not required. The reordered notification requirements in the post-hearing document acknowledge the five situations cited by the Commenter where the 30-day notification is not required, leaving only situations when failure to pay, or a facility ceases to operate, trigger a 30-day notice requirement. [The situation of misrepresentation of finances is a separate state-only regulatory

requirement addressed in Comment 10.A, and requires what is determined by the Department to be reasonable notice, that is, 30 days.]

H. Comment: Advising residents of their appeal rights is not required to be included in the Agreement, and adds an additional contract term for which the facility may incur liability. Requests that this language be removed.
Commenters: 898.21

Department Response:
DHS believes inclusion of this language is appropriate, because HSC §1599.75(c) requires that residents be informed of their right to contact the Department or the Ombudsman regarding grievances against the facility. Also, 42CFR 483.12(a)(6)(iv) and (v) provide that information regarding appeal rights be included in transfer notifications. DHS asserts that a resident who is subject to an involuntary transfer or discharge should be notified of their rights, and be aware of possible recourse.

I. Comment: DHS has no authority to require the facility to continue care for the resident after discharge. Suggest removing the words "for continuing care."
Commenters: 898.21

Department Response:
DHS agrees with the comment, and has revised the Agreement language (page 13 of the post-hearing document) to conform with statute (HSC §1599.78).

J. Comment: Suggests change in language to make resident responsible for any charges for a certified bed beyond what is covered by Medi-Cal's daily rate.
Commenters: 898.21

Department Response:
DHS disagrees with this recommendation, since under 22CCR 51002(a), the Medi-Cal rate represents payment-in-full, and facilities are prohibited from soliciting or accepting supplements to such charges.

K. Comment: Language that states a resident "may leave the facility at any time without prior notice" does not apply to LPS-conserved involuntary patients admitted by court-appointed conservators to a locked facility. This statement should be modified to clarify under what circumstances a resident may leave the facility.
Commenter: 904.5

Department Response:
DHS notes the comment, and assumes that this and other issues related to LPS-conserved involuntary resident will be addressed through program flex requests.

L. Comment: The phrase "against your wishes" in reference to an involuntary transfer or discharge should be eliminated and the word "involuntary" used instead, because it conforms with statutory requirements.

Commenter: 898.21
Department Response:
DHS disagrees with the need for this change. The plain English phrase "against your wishes" does not contradict the meaning of the word "involuntary," nor counter statutory language used to describe an involuntary transfer or discharge, as per HSC 1599.76 and 42CFR 483.12 et seq. Also, "against your wishes" conforms with the definition of "involuntary" as stated in Webster's New World Dictionary (Third College Edition, 1988), "not done of one's own free will; not done by choice."

11. Bed-holds.
A. Comment: Bed-holds only apply to Medi-Cal patients, not Medicare patients, and are limited to seven days. Commenter notes that if a resident is eligible under Medi-Cal and a physician states the patient will be staying in a general acute care hospital, Medi-Cal will not cover the bed-hold, even is the stay is for seven or less days. Suggests new language to clarify their concerns.
Commenter adds that federal law only requires this information be established in the facility policy and provided to the resident at the time of transfer along with the notice of rights to a bed-hold. Further asks by what authority does this provision belong in the Agreement, noting that CFR 483.12(b)(3) does not impose this requirement, and therefore questions the necessity of this statement.
Commenters: 896.15, 898.22

Department Response:
The Department has revised the language in the Standard Admission Agreement to remove the implication that Medicare will pay for a bed-hold (page 14 of the post-hearing document). However, DHS does not agree with the commenters' interpretation of regulations, and believes that bed-hold provisions are appropriately included in the Agreement, as noted in the Initial Statement of Reasons (page 20) and found in HSC§1599.79, 22CCR §72520, and 42CFR 483.12(b)(3).
These statutes and regulations require the facility to establish and follow written procedures with regard to bed-holds. Although these provisions are not mandated in the Agreement, the Department believes that the purpose of the Standard Admission Agreement is to inform the resident about the facility's policies and their rights as residents prior to signing the Agreement. These statements in the Standard Admission Agreement reiterate and clarify federal and state laws and regulations pertaining to bed-hold procedures.

B. Comment: Commenter adds elimination of blank space in the Standard Admission Agreement for amount a private-pay resident is responsible for paying for a bed-hold, and instead substitute phrase "the daily rate."
Commenter: 898.22
Department Response:
The Department does not agree with the commenters' recommendation, since the amount could differ depending on whether meals and other charges are applied to the bed-hold, and may vary by facility. The Agreement language mirrors provisions for charges for private pay residents in Financial Arrangements, Section A.

12. Financial Arrangements: Share of Costs.

A. Comment: *Seeks clarification regarding respective payment responsibilities if* the resident applies for Medi-Cal, and seek approval under program flex to include the following language for share-of-cost and the consequences of failure to pay: "Medi-Cal, Medicare, or a private payor may require that the Resident pay a co-payment, co-insurance, or a deductible, all of which the Facility considers to be the Resident's share of cost. Failure by the Resident to pay his or her share of cost constitutes grounds for discharge of the Resident."

Commenters: 9.2, 14.2, 17.2, 24.2, 26.2, 31.2; 333.1-390.1; 555.2-652.2; 896.13; 898.16; 908.2; 909.2; 911.11

Department Response:

The Department acknowledges these comments, and has revised the Agreement language (pp. 5, 9 of the post-hearing document) to address share-of-cost concerns in the Financial Arrangements section of the Agreement.

B. Comment: Seek approval under program flex to include language allowing a resident the option of having their social security check mailed directly to the facility to pay for their share of cost, and provide suggested language, noting that it is a commonly used practice.

Commenters: 15.1; 282.1-332.1

Department Response:

This disagrees; such an arrangement would violate22CCR §72529(c): "No licensee, owner, administrator, employee or their immediate relative or representatives of the aforementioned may act as an authorized representative of patient's [resident's] monies or valuables, unless the patient [resident] is a relative within the second degree of consanguinity."

13. Financial Arrangements: Liability of Resident's Representative.

Comment: Provision in the Agreement that "a Residents Representative who signs this Agreement on behalf of the Resident assumes no personal financial liability . . . " is false and misleading, as is the Department's rationale for this in the Initial Statement of Reasons.

Commenters refer to page 8 of the Initial Statement of Reasons, that the law allowed the facility to require, as a condition of admission and where a resident has an agent, that the resident's agent sign or co-sign the Standard Admission Agreement and agree to distribute to the facility any share of cost as well as any other charges not paid for by Medi-Cal for which the resident has agreed to pay. The proposed regulation language must be modified to be consistent with the law, specifically HSC §1599.65 and WIC §14110.8.

Commenters: 555.1-602.1; 603.2-652.2; 896.10; 898.12; 908.2; 909.2; 911.6

Department Response:

The Department does not agree with the commenters' interpretation of the cited statutes, or that this language is false and misleading. The Initial Statement of Reasons clearly defines a representative's financial responsibility in this regard:

"If the resident's representative has legal control of the income and assets of the resident (for example, as a conservator), then that representative has the authority and separate legal responsibility to use the resident's assets and income to pay for the costs of care provided to the resident..."

However, the Standard Admission Agreement has been revised (page 2 of the post-hearing document) to clarify identification of parties to the Agreement as "Family Member," "Legal Representative," "Responsible Party," or "Agent" at the start of Section II. Language has also been changed (page 2 of the post-hearing document) to emphasize that a resident's representative assumes no "PERSONAL" [capitals added for emphasis] financial obligation by voluntarily signing the Agreement. As cited in 42CFR 483.12 (d)(2): "The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources."

HSC §1599.65(b) provides that no facility "require or solicit as a condition of admission that a Medi-Cal beneficiary have a responsible party sign or cosign a contract of admission." Further, WIC §14110.8(b) states: "No facility may require or solicit, as a condition of admission into the facility, that a Medi-Cal beneficiary have a responsible party sign or cosign the Standard Admission Agreement. No facility may accept or receive, as a condition of admission into the facility, the signature or co signature of a responsible party for a Medi-Cal beneficiary." DHS believes that the language of the Agreement is consistent with statutes.

[Also, it should be noted the phrase *"To the extent permitted by law,"* was added to the sentence *"To the extent permitted by law, you may designate a person as your Representative at any time."* This non-substantive change was made to the Agreement in response to a 15-day comment (Addendum IV, Comment 12.A), to recognize the relevance of current law with all applicable statutes, and to conform with Consent to Treatment provisions in Section III.]

14. Financial Arrangements: Payor Classifications

A. Comment: The Standard Admission Agreement does not sufficiently clarify the resident payment categories in Section V, or delineate clearly between "private pay," "Medi-Cal," "Medicare," and "private insurance," and resident classifications should be consistently applied throughout the Agreement. A commenter recommends that the Department include instructions that clarify the scope of the four payment classifications above, while another suggest a list of nine different payment categories for inclusion in the Standard Admission Agreement. One commenter also provides an alternative schedule (Attachment C to Comment Letter 896) restating supplies and services included in the basic daily rate for Medi-Cal residents.

Commenters also recommend that the Agreement adopt the exact wording of HSC §1599.69 regarding Medi-Cal/private pay status of residents, noting that DHS, in an effort to draft in "plain language," has altered the meaning of the statute.
Commenters: 896.13; 896 (Attachment C); 898.16; 911.9

Department Response:
DHS has revised the Agreement to further delineate payor sources (see page 5 of the post-hearing document). The Financial Arrangements section of the Agreement has been expanded from four to seven categories of residents according to their source of payment (including "Medicare, Part A," "Medicare, Part B," and "Other") to address this concern. Financial responsibilities, with attachments specifying supplies and services for each are delineated in the Agreement. DHS believes that its attachments most clearly provide a mechanism for specifying charges for supplies and services for each type of payment provider.

B. Financial Arrangements: Payment Provisions
Comment: The following language in the Standard Admission Agreement, "If you are entitled to benefits under these programs and if we participate as a provider in these same programs, we agree to accept payment form them instead of our basic daily rate" should be eliminated because is not essential contract language, and does not address share of cost issues. Another Commenter suggests instead that the sentence be clarified and provides suggested language.
Commenters: 898.16; 911.11

Department Response:
DHS does not agree that this language is unessential to the Agreement; however, the language has been revised in response to the second comment, to clarify payment provisions (page 9-10 of the post-hearing document).

Share-of-cost provisions have been added to the Financial Arrangements section in response to comments (see Comment 12.A).

15. Medi-Cal/ Medicare.
A. Comment: Note that the Standard Admission Agreement misstates federal law relating to financial guarantees, which apply to every resident of a facility certified for Medi-Cal or Medicare, and suggest the following revision to page 2 of the proposed Agreement:

"If our facility participates in the Medi-Cal or Medicare Program ~~and you are eligible for one or both of those programs~~, our facility does not require that you have anyone guarantee payment for your care by signing or cosigning this admission agreement as a condition of admission"
Commenters: 894.3; 896.13; PH 5.3

Department Response:
DHS agrees with this comment, and has revised the Agreement (page 3 of the post-hearing document) to address this issue.

B. Comment: Requests the following revision to Agreement language because it places a facility with the responsibility of determining a resident's Medicare/Medi-Cal eligibility:
"If our facility participates in the Medi-Cal or Medicare Program and you do not know whether your care in our facility can be covered... ~~we will help you get the information you need.~~"

Commenters note that under WIC §14110.8(e), it is the county's role to determine Medi-Cal eligibility; facilities are required to make reasonable attempts to assist the resident in contacting the county, while the federal statutes require that facilities "furnish a written description of the requirements and procedures for establishing eligibility for Medicaid." They add that this language creates a contractual responsibility not currently required by law, and exposes facilities to potential liability, and ask that the language be clarified or eliminated.

Also provides extensive additional contract language outlining a resident's specific responsibilities in applying for and receiving Medi-Cal. Seeks response whether contracts may be altered under program flexibility to include such language.
Commenters: 4.1; 6.1; 10.1; 12.1; 16.1; 21.1; 32.1; 160B.1-221.1; 898.16; 912.2

Department Response:
DHS does not agree with the suggested revisions, since the Agreement requires only that facilities provide residents with information regarding the Medi-Cal and Medicare programs, not make eligibility determinations. Facilities are required under WIC §14006.4 and 42CFR 483.10(b)(10) to provide information regarding how and where to access Medi-Cal and Medicare information. Facilities that do not participate in those programs are recognized in the same paragraph by the following language:

"You should note that, if our Facility does not participate in Medi-Cal or Medicare and you later want these programs to cover the cost of your care, you may be required to leave our Facility."

The Department has revised this paragraph to remove redundant language (page 5 of the post-hearing change document).

C. Comment: Financial Arrangements Section of the Agreement should be revised to include notification to residents if a nursing facility has submitted its intention to withdraw from Medi-Cal, as required by Welfare & Institutions Code §14022.4, and provides suggested language for inclusion to the Standard Admission Agreement.
Commenter: 894.6; 897.3

Department Response:
DHS agrees that residents should be aware of their rights under Medi-Cal, and has made the requested revision to the Agreement (page 6 of the post-hearing document).

[It should be noted that the Department has inserted "*[APPLICABLE ONLY IF DATE IS ENTERED:]*" to the disclaimer paragraph regarding a facility's withdrawal from Medi-Cal, following a 15-day notice comment (see Comments 4.A-C of Addendum IV). DHS considers this to be a non-substantive, technical change to the Agreement to clarify the applicability of the disclaimer.]

D. Comment: Medi-Cal eligibility: requests that the Standard Admission Agreement be revised to include Medi-Cal eligibility rules set forth in DHS Form 7077, as an Attachment C-4 to the Agreement. This language is codified in WIC §14006.4, and would assist in reminding residents of how and where to access Medi-Cal information.
Commenters: 894.7; 897.4

Department Response:
DHS disagrees that is necessary to include Medi-Cal eligibility information as an attachment to the Agreement. As noted in the comment, the Welfare and Institutions Code requires that facilities provide the information to residents, and the Department believes they are sufficiently informed under current statute (WIC §14006.4 et seq.).

E. Comment: Right to appeal an unfavorable Medi-Cal coverage decision: requests that the Financial Arrangements Section of the Agreement inform residents of their options if they receive an unfavorable decision regarding coverage of services, and suggests the following additional language:
"Depending on the decision from Medi-Cal, you may have the right to appeal the denial, or to use your monthly share of cost deductible to pay for the supply or service."
Commenter: 894.8

Department Response:
The Department has revised this language in the Agreement (page 10 of the post-hearing document) to clarify the resident's options in the event of an unfavorable Medi-Cal coverage decision. DHS agrees that residents should be aware of their rights under Medi-Cal, but believes that residents adequately informed of them under 22CCR §72527(2) 42CFR 483.10(b)(10), which is included in Attachment A to the Standard Admission Agreement. WIC §14133.05 et seq. provides for appeal of a resident's Treatment Authorization Request; however, the suggested revision is confusing and would not provide for additional clarity regarding that process.

F. Comment: Requests revised Financial Arrangements language as follows:
"You should note that Medi-Cal, Medicare, or other insurance payors will only pay for covered supplies and services if they are medically necessary. ~~If Medi-Cal~~

~~determines that a supply or service is not medically necessary, we will inform you of that and ask whether you still want that supply or service and will pay for it yourself.~~"
Commenter: 898.17

Department Response:
DHS disagrees with the suggested revision (see Comment 15.E), since this payment provision relates only to advising Medi-Cal residents about covered services and their responsibility to request any supply or service not covered by Medi-Cal. As noted in the Initial Statement of Reasons, DHS has deemed this an important advisory for such residents. Medicare provisions are addressed in Attachment D-1; private payor insurance provisions are not within the scope of these regulations.

[It should also be noted that in its 15-day post-hearing changes the Department erroneously included the words *"or your physician"* in the first sentence, *"We will only charge you for optional supplies and services that you or your physician specifically request..."* The phrase was removed, and the corrected language mirrors identical Agreement language in Financial Arrangements, Section A provisions for private pay residents.]

G. Comment: The Standard Admission Agreement should be revised to emphasize a resident's rights with regard to transfers while a Medi-Cal application is pending.
Commenter: 894.10

Department Response:
DHS believes that residents are adequately informed of valid reasons for transfers under Section VI of the Agreement (see responses to Comments 10.A-10.J).

H. Comment: Residents' readmission rights under Medicare: the Standard Admission Agreement inaccurately states that Medicare eligibility creates a readmission right, and expands those rights; they recommend language that would clarify those rights, in conformance with federal regulation, by making the following revisions to the Standard Admission Agreement (page 21):

"You should also note that, if our Facility participates in Medi-Cal ~~or Medicare~~ and your are eligible for Med-Cal, if ~~and~~ you are away from our Facility for more than seven days due to hospitalization or other medical treatment, we will readmit you to the first available bed in a semi-private room if you need the care provided by our Facility and wish to be readmitted."
Commenter: 894.11

Department Response:
The Department acknowledges this comment, and has made the recommended change to the Agreement (page 14 of the post-hearing document).

I. Comment: Cites errors in attachments C-1 and C-2, regarding services covered under Medi-Cal: failure to note that respiratory therapy is not a stand-alone service,

and is only included in the daily rate for pediatric subacute facilities; payment for incontinence supplies should be clarified; services not included in the Medi-Cal daily rate that are allied health services should be noted; services "provided under the Department of Social Services regulations" (Attachment C-2) should be clarified or eliminated from the schedule; and that laundry service, which is included in the Medi-Cal daily rate, is omitted from schedule in C-1, and personal transportation is omitted from Schedule C-2. Commenters also point out that Medi-Cal, Medicare and other insurance payors will only pay for covered supplies and services if they are medically necessary.
Commenters: 894.13; 896.20; 898.17; 911.16

Department Response:
The Department acknowledges this comments and has made the requested changes to the appropriate schedules to include laundry and transportation services as Medi-Cal benefits, and has eliminated reference to Department of Social Services regulations (Schedules C-1 and C-2 of the post-hearing document). All other benefits are listed in accordance with 22CCR §51123, §51321, and §51511, and do not require clarification. Also, it should be noted that optional supplies and services not covered in the Medi-Cal daily rate that may be purchased by Medi-Cal residents are to be listed on Attachment C-3; Attachment D-2 serves a similar purpose for Medicare residents, as does Attachment B-2 for private pay and privately insured residents.

J. **Comment:** Notes that the Department is to include in Attachment D-1 a two-page excerpt from the CMS publication "Your Medicare Benefits" to provide relevant information about Medicare payments for nursing facility expenses. Commenter recommends that the Department use excerpts from pages 1-3, 11-12, and 21-21 of another CMS publication, "Medicare Coverage of Skilled Nursing Facility Care," to explain Medicare nursing facility benefits and notice and appeal rights.
Commenter: 894.14; 896.21

Department Response:
DHS has included the Medicare benefits information indicated in the Initial Statement of Reasons in Attachment D-1, which also provides directions to additional information available at the Medicare website, or via a toll-free number, noted in the attachment. The Department disagrees with the suggestion to use the suggested CMS excerpts, which are less concise than the CMS guidance provided.

16. Financial Arrangements: Optional Supplies and Services.
A. Comment: Commenter notes that the Department, in the Initial Statement of Reasons, acknowledges that state law does not require that facilities must charge residents only for optional supplies and services that the resident specifically requests. The commenter states that there is no statutory authority for this provision in the Standard Admission Agreement, and it is a new requirement that is outside the regulatory process. Recommends its deletion from the Agreement, citing

instances where the facility is responsible for seeing that the needs of many elderly patients who have no one else are fulfilled, and optional supplies and services are obtained by the facility. Another comment notes that optional supplies and services are often ordered by a resident's physician, not the resident, who makes a decision that they would be beneficial for the resident.
Commenters: 896.13; 911.10

Department Response:
DHS disagrees with the proposed deletion. In the Initial Statement of Reasons (page 16), the Department explains its rationale for advising residents of the Medi-Cal program's process for determining the medical necessity of covered benefits, and their need to request any supply or service not covered by Medi-Cal or Medicare. An identical advisory for private pay residents is included in subsection A of the Financial Arrangements section of the Agreement. This language is consistent with federal regulation 42CFR 483.10(c)(8)(iii), which provides "The facility must not charge a resident...for any item or service not requested by the resident."

Additionally, under 22CCR §72528(a) (included in Attachment A of the Agreement), it is the responsibility of a resident's physician to inform a resident of the medical necessity for a supply or service that the physician orders for the resident. 22CCR §72527(a)(2) (also included in Attachment A) states that a resident has a right to be fully informed "of services available in the facility and of related charges," including those not covered by per diem rates. Optional supplies or services obtained by a facility for a resident must conform with 22CCR §72529(e) requirements (also included in Attachment A) for safeguards for resident's monies and valuables, and be purchased only by authorized signatories to the resident's account. No new regulatory requirement is imposed by the Agreement in this regard.

B. Comment: Notes that residents and facilities may enter into separate pharmacy service agreements outside the Standard Admission Agreement, and seeks guidance on adding such attachments to the Agreement.
Commenter: 896.13; 898.17

Department Response:
The Department does not agree that pharmacy services agreements be included as an attachment to the Standard Admission Agreement, since they are specific for the particular resident and situation. As noted in the response to Comment 4.A, statutory procedures exist for obtaining program flexibility for such situations.

17. Financial Arrangements: Security Deposits.
A. Comments: DHS has no statutory authority to disclose how the security deposit will be used by the facility; requests that this provision be removed or revised.
Commenters: 896.13, 898.19

Department Response:
DHS has deleted this Agreement language (pages 8-9 of the post-hearing document) in response to comments. As noted in the Initial Statement of Reasons, state law does not prohibit facilities from collecting a security deposit from private pay or privately insured residents, and the revised language allows the facility and the resident to negotiate mutually agreeable security deposit arrangements.

B. Comment: There should be a distinction between security deposits and advance payments, also known as prepayments. The commenter stated that although these payments may have similarities, there are differences and should be addressed separately in Financial Arrangements.
Commenter: 911.13

Department Response:
The Department disagrees with the proposed addition to the Standard Admission Agreement, since advance payment provisions (if any) for private pay residents are unique to each facility, and could be added via a program flex request.

C. Comments: States that current regulation, 22CCR §72531 is outdated; facilities do not "rent space" and the Medi-Cal program does not "rent space" in SNFs.
Commenter: 896.13

Department Response:
The Department acknowledges the comments. Although these terms may not reflect current vernacular, they describe a contractual agreement between a resident and facility in conformance with current regulations. Amending this terminology is outside the scope of these regulations.

D. Comment: The 14-day refund after discharge is not required by law and DHS does not have the authority to extend it from one concept to another area simply because DHS "believes it is a reasonable interpretation of Legislative intent." Therefore this language should be eliminated.
Commenter: 898.20; PH 2.7

Department Response:
The Department disagrees with the comment, and believes that 14 days is a reasonable period for the return of all resident refunds and other overpayments. As noted in the Initial Statement of Reasons, 22CCR 72531(b) requires that any advance must be returned within two weeks of a resident's discharge or death, and HSC 1599.70 has a similar refund requirement for a private payor who switches to Medi-Cal payments.

18. Financial Arrangements: Interest Charges.
Comment: Provisions in the Financial Arrangements, subsection C, Billing and Payment, state that a late charge at an unspecified rate of interest may be charged

on past due accounts; according to the Commenters, California law prohibits businesses from charging interest per month on late payments (*Southwest Concrete Products v. Gosh Construction Corporation* (1990) 51 Cal. 3d.701). The commenters recommend that the section should be modified to clarify that a facility can charge a fixed late fee.
Commenters: 896.13; 898.18

Department Response:
The Department disagrees with this comment. Under HSC §1599.68, "Any long-term healthcare facility that imposes interest charges on delinquent accounts shall clearly state in the contract of admission the rate of interest so charged and the method of computation." The Standard Admission Agreement language complies with this statutory requirement; additionally, the case cited is not applicable to this Agreement.

19. Financial Arrangements: Billing and Payment.
Comment: Requests that the Department revise Financial Arrangements, subsection C language as follows: "We will provide to you an itemized statement of charges that you must pay ~~from you own resources~~ every month." Commenter notes that statute requires only that a facility provide monthly statements itemizing all charges incurred by a resident, and the source of payment is not relevant to the Agreement.
Commenter: 898.18

Department Response:
The Department acknowledges this recommendation, and has revised the Agreement (page 11 of the post-hearing document), to conform with the requirements of HSC §1599.67.

20. Theft and Loss.
A. Comment: In written and public testimony the Office of the Long-Term Care Ombudsman suggests that the statutory protections regarding theft and loss in HSC §1418.7(b) be specified in the Agreement, as it would be a stronger standard than the facility's theft and loss policy.
Commenter: 895.5; PH 1.6

Department Response:
The Department does not agree that restating the law in the Standard Admission Agreement would make the strengthen theft and loss standards in any way, and would only serve to unnecessarily lengthen the Agreement. As noted in the Initial Statement of Reasons, facility theft and loss policies are required by HSC §§1289.4 and 1418.7(b) to meet specific standards, and be provided to residents. The facility's responsibility to inform new residents about theft and loss policies and procedures is clearly specified.

B. Comment: States there is no statutory requirement to provide policies and procedures with regard to theft and loss, or to provide copies of statutory requirements to the resident. The law only requires that the facility establish a theft and loss policy; requests that this language be struck from the Agreement. Argues that the Department has constructed an additional contract term, thereby potentially incurring additional liability on the part of the facility, and that inclusion of this instead of arbitration agreements in the Standard Admission Agreement is inconsistent with the law.
Commenter: 896.16; 898.23

Department Response:
The Department disagrees; as noted in the Initial Statement of Reasons, HSC §§1418.7 and 1289.4(l) require that notification of a facility's theft and loss policies be provided to residents upon admission, and the Department believes it is important to advise residents of their rights in this regard. This is consistent with the facility's responsibility to safeguard residents' property and valuables, as noted in 22CCR §72529(d), included in the Resident Bill of Rights (Attachment A of the Agreement).

Reference to theft and loss policy requirements in the Standard Admission Agreement does not create additional liability, since facilities are held to the statutory requirements regardless of whether or not they are included in the Agreement. Finally, use of an arbitration agreement is permitted, but not mandated, by law, whereas theft and loss policies are not optional on the part of facilities.

21. Photographs.
Comment: Requests that the Department eliminate reference to a resident's photographs in Section IX of the Standard Admission Agreement "for identification and healthcare purposes." The commenter notes that the Department acknowledges in Initial Statement of Reasons that this is not required by state law to be included in the Standard Admission Agreement, and requests that program flexibility be granted to facilities to permit a consent form signed by a resident, to allow photographs to be taken.
Commenter: 898.24

Department Response:
The Department disagrees with this suggestion. While SB 1061 did not address the issue of resident photographs in the Standard Admission Agreement, HSC §1599.80 does not preclude its inclusion, and DHS believes the requirement logically belongs in the Agreement. To eliminate it from the Standard Admission Agreement, and then request program flexibility to add it in a separate agreement would not be efficient.

22. Grievance procedures.
Comment: Requests that the Department revise Section XI, related to Facility Rules and Grievance Procedures, as follows: "You have an obligation to observe facility rules. Our facility rules must be reasonable and include ~~You agree to comply with reasonable rules, policies, and procedures that we establish. When you are admitted, we will give you a copy of those rules, policies, and procedures, including~~ a procedure for you to suggest changes to them. ~~We will also give you~~ A copy of our grievance procedure for resolution of any complaints you may have about our Facility is available upon request. You may also contact the following agencies about any grievance or complaint you may have: ..."

The commenter states that the proposed revision conforms with the requirements of §1599.61(b) of the Health and Safety Code, while that the Department's proposed language creates additional contractual obligations on facilities that may create a liability, particularly since the Standard Admission Agreement does not clarify whether facilities may request that residents sign a form acknowledging the information and materials the receive during or after the admission process (such as a copy of the grievance procedures).
Commenter: 898.26

Department Response:
The Department does not agree that the requested revision to the Standard Admission Agreement would substantially alter its meaning, other than relieving a facility of the requirement to give a resident a copy of its grievance procedure. As noted in the Initial Statement of Reasons, HSC §1599.75 requires that a facility inform residents of the availability of its grievance procedure; we do not believe that providing a copy of the procedure to the resident is an onerous requirement, or that it creates an additional contractual obligation.

As noted in the response to Comment 20.B, inclusion or absence of an existing statutory requirement in the Agreement does not alter a facility's legal obligations to meet that standard. Finally, if a facility requests written acknowledgement of receipt of such information from a resident, it is not precluded from doing so following admission. Currently, only the Resident Bill of Rights requires a separate written acknowledgement of receipt, under Health and Safety Code §1599.74(c).

23. HIPAA Compliance.
A. Comments: As written, the "Confidentiality of Your Medical Information" in Section X of the Agreement is not HIPAA compliant.
Commenters: 40; 760-774; 827; 896.17, 896.22; 904.6; 908.4; 911.14

Department Response:
As noted in the Initial Statement of Reasons, Attachment E (described in Section X) is included pursuant to HSC §1599.73, which requires that every contract of admission shall "provide a means by which the resident may authorize the

disclosure of information." The Department has revised the Resident Bill of Rights to conform with current state and federal regulations regarding rights to confidentiality of medical information. It does not agree that HIPAA privacy rules should be included in the Standard Admission Agreement, since the Agreement is not intended to address HIPAA issues, which relate to sharing of information among and by covered entities, and which are enforced under federal statute. The purpose of the Attachment E, Authorization for Disclosure of Medical Information, is to provide a mechanism for a resident to designate a person to whom the facility may communicate as needed about the resident's medical issues.

B. Comment: Although HSC §1599.73 requires facilities to provide a means by which the resident may authorize release of information, Commenter states that the form omits important HIPAA privacy rules (42 CFR 164.506) requirements, including consent for the use and disclosure of protected health information. Suggests inclusion of language on the form, and also include new formatting on Attachment E.
Commenter: 898.25

Department Response:
The Department disagrees that it is necessary to include additional HIPAA information with the Standard Admission Agreement, since it is outside the scope of these regulations and would pertain only for covered entities. No facility is relieved of its separate obligations to meet HIPAA compliance by the absence of HIPAA information in this Agreement.

C. Comment: Asks if the use of Attachment E is mandated in addition to the privacy practices prescribed by HIPAA; states that attachment appears to be redundant and possibly confusing to consumers and family members.
Commenter 904.6

Department Response:
As noted in the response to Comment 23.B, Attachment E is mandated by HSC §1599.73, to provide a means by which a resident may authorize the disclosure of medical information for certain purposes. Hence, the Department does not agree that Attachment E is redundant; please also refer to response to Comment 23.A.

D. Comment: Recommends use of HIPAA-compliant attachment to the Standard Admission Agreement, with acknowledgment of receipt by resident.
Commenter: 911.14

Department Response:
The Department disagrees; please see responses to Comments 23.A and 23.B.

24. Section XII – Entire Agreement Provisions.
A. Comment: The provision in Section XII of the Agreement is inconsistent with HSC §1599.651, which allows for a resident readmitted to the facility where a

previously executed agreement exists to modify that agreement. It is unclear if this provision requires the facility to execute a new agreement for readmitted residents.
Commenter: 896.18

Department Response:
The Department does not agree that Section XII provisions of the Standard Admission Agreement preclude the extension of an existing contract for readmission under the provisions of HSC §1599.651. The statute specifies the conditions under which a previously executed contract may be used by a readmitted resident in lieu of a new agreement.

B. Comment: The Agreement should acknowledge that a resident is entitled to a copy of the signed Agreement, and receipt for any payments made upon admission, by including the following language: "We will provide you with a copy of the signed Agreement, all attachments and any other documents you sign at admission and provide you with a receipt for any payments you make at admission."
Commenter: 894.12; 897.5
Department Response:
The Department agrees, and has made the recommended change to the Agreement (page 16 of the post-hearing document).

C. Comment: Several "general contract terms" regarding invalid provisions, waivers, assignment, and other legal terminology must be added to the Agreement.
Commenter: 898.27

Department Response:
The Department agrees that some of the suggested additions are "general contract terms," and has added several commonly used legal clauses to the Standard Admission Agreement, related to invalid provisions, waivers, captions and headings, jurisdiction for disputes (California-specific only), and assignment.

Complete agreement provisions already exist in the Entire Agreement section of the Agreement. Finally, the Department believes provisions related to Force Majeure and attorneys fees are too broadly constructed, and are not appropriate for inclusion in a Standard Admission Agreement for nursing facility services.

25. Impact on small business.
A. Comments: DHS failed to recognize an impact on small business as it relates to facility printing costs, increased risk to litigation, and additional staff time necessary for explaining "other" admission items at a time separate from the admission.
Commenter: 896.24

Department Response:
The Department disagrees with these comments, and believes the availability of a uniform Standard Admission Agreement may prove to be less expensive for facilities

to produce and distribute, since it will be available online following its introduction. DHS does not agree that there is an increased risk of litigation associated with the Standard Admission Agreement, since it is mandated by statute. Also, we would dispute the notion that additional staff time will be required to explain "other" facility issues separately from the Agreement, because the Department has not added requirements beyond use of the Standard Admission Agreement.

B. Comment: Reiterates the comment that the Department has added numerous additional contractual requirements on facilities, thereby exposing facilities to potential exposure due to breach of contract. In addition, prohibition of arbitration clauses in the Agreement adds to increased liability on the part of a facility.
Commenter: 898.28

Department Response:
The Department does not agree that the Standard Admission Agreement increases liability due to the addition of contractual terms; on the contrary, it has standardized the terms in conformance with applicable laws and regulations.
As noted in responses to Comments 2.A et seq., arbitration agreements are not precluded from use, as long as they are presented and signed separately from the Standard Admission Agreement. Please see responses to Comments 2.A-2.Y for more complete discussion of this issue.

C. Comment: States that HSC §1599.74 requires the Department to translate the document into Spanish and Chinese and into other languages as needed. Questions whether DHS is planning to translate the Standard Admission Agreement into these languages. Commenter states that the cost to facilities to do this is excessive, and that the translation should be a responsibility of the DHS.
Commenter: 898.29

Department Response:
As stipulated in HSC §1599.74, the Department shall translate both the statutory and regulatory Resident Bill of Rights into Spanish, Chinese, Braille and other languages as needed for ethnic groups representing one (1) percent or more of the facility population in the state. The statute does not require the Department to translate the Standard Admission Agreement into these languages.

26. Olmstead Decision.
Comment: Request that the Department include language recognizing the Olmstead Decision and the pending state plan to implement it in the Standard Admission Agreement. They believe that it would be appropriate for residents to be informed of their right to care in a community-based setting and to be given a referral to information about such alternatives in their treatment plans within the framework of the Standard Admission Agreement, and throughout the admission process.
Commenters: 902.3; 905.3

Department Response:
DHS does not agree that language recognizing the Olmstead Decision should be included in the Standard Admission Agreement. This language is relevant to a discharge, not to an admission to a facility, and moreover has not been mandated by statute for inclusion in the Standard Admission Agreement.

27. Admission standards for SNF providers.
Comment: Notes that the Department, in its proposed regulations, has unfairly applied admission standards to facilities that are not found in any other level of healthcare in California (including hospitals or HMOs), and state that no other provider is subject to such restrictions on admissions.
Commenter: 903.2

Department Response:
The Department disagrees with this comment, and has complied with the mandates of HSC §1599.61 et seq., and with all state and federal statutory authority, in drafting these regulations. The commenter has not sufficiently defined less restrictive admission standards that would suffice in fulfilling the mandates of SB 1061.

28. Admission requirements for SNF-STPs.
Comment: A facility operator of statewide Skilled Nursing Facilities with Special Treatment Programs (SNF-STPs) states that the proposed Standard Admission Agreement regulations present significant problems for such facilities, noting that "many aspects of providing mental health services to an LPS [involuntarily] conserved patient do not fit within the proposed standardized agreement." The commenter provides a number of examples of the inappropriateness of the Standard Admission Agreement for their treatment setting, including provisions for Consent to Treatment, expansion of specific services provided and payor categories under Financial Arrangements, limits to Transfers and Discharges, and Confidentiality of Medical Information.

The commenter adds that the type and extent of modifications needed to the Standard Admission Agreement for its use by SNF-STPs would eliminate its benefits, unless the Department develops a standardized agreement for these specialized facilities. The commenter requests that the Department specify the standards and timeframes to be used for approving requests for modifications to the Standard Admission Agreement, and what mechanism will be available to providers for appeal denials. The commenter also proposes that DHS exempt their facilities from being required to use the Standard Admission Agreement, or establish an expedited review and approval process for submitting requests for modification.
Commenter: 898.3; 904.1; 904.4

Department Response:
The Department has revised the Consent to Treatment provisions in response to this recommendation, and also expanded the definitions of payor categories. DHS believes that addition of the phrase "to the extent permitted by law" to the resident's right to refuse any treatment restricts an LPS-conserved involuntary resident from "leaving the facility at any time" under the Transfer and Discharge provisions of the Standard Admission Agreement. (Please also see Comment 8.A)

We anticipate that other revisions to the Standard Admission Agreement for SNF-STP facilities will be considered through program flex provisions under HSC §1276 et seq. to address the particular needs of such facilities. DHS does not have the authority under SB 1061 to exempt any licensed nursing facility from the requirements of the statute, nor may it develop a separate standardized admission agreement specific to their needs.

29. Admission requirements for Distinct Parts (DPs).
Comment: The Standard Admission Agreement should not apply to Distinct Part Nursing Facilities (DP/NFs); to do so would contradict the Department's earlier legal opinions. Commenter cites two letters in which DHS states that DP/NFs are not required to use the Standard Admission Agreement, and points out that the majority of their patients are admitted to their facilities immediately following a stay in the acute care side of a hospital, for which they have already complete admission paperwork.
***Commenter:* 911.1**

Department Response:
In its post-hearing change availability the Department agreed with the comment that residents of such facilities have already completed admission agreements for DP/NFs (or DP/SNFs or DP/ICFs) and should not be required to use the Standard Admission Agreement. DHS drafted proposed revisions to 22CCR §§70503 and 70627 regulations to exempt such facilities from the requirements SB 1061 and provided them for 15-day public review.

In making this revision to the proposed regulations, DHS also reasoned that the Standard Admission Agreement was not applicable to DP/NFs (or to DP/SNFs or DP/ICFs) because they are not licensed as skilled nursing or intermediate care facilities, but are sub-units of a different type of licensed healthcare facility. However, following review, and in response to 15-day public notice comments received, the Department has concluded that these facilities are not exempt from the requirements of HSC §1599.61.

DHS has determined that the Standard Admission Agreement should apply to residents of all nursing facilities in California, including DP/NFs, DP/SNFs and DP/ICFs because HSC §1599.61(a) requires its use by all facilities as defined under HSC §1250(c), skilled nursing facilities, HSC §1250(d), intermediate care, and HSC

§1250(k), nursing facilities. Additionally, "skilled nursing facilities" are defined in 22CCR 72103 to include both freestanding facilities and facilities which operate as a distinct part of a hospital, and 22CCR 73051 defines "intermediate care facilities" to include both freestanding facilities and those that operate as a distinct part of a hospital. The Department is authorized, under HSC §1275 to develop regulations governing such facilities.

Finally, one letter cited by the Commenter exempting DP/NFs from admission contract requirements predates the passage of SB 1061, which established the requirements HSC §1599.61, and the second predates the passage of AB 1731 (Ch. 451, Stats. 2000), which defines nursing facilities under HSC §1250(b), (c), and (k).

[Please refer to Addendum IV, Comments 2.A-2.F, and the Final Statement of Reasons for further discussion of this issue.]

30. California Department of Veterans Affairs facilities.
A. Comment: The California Department of Veterans Affairs (CDVA) recommends that DHS exempt veterans homes from the requirement to use the Standard Admission Agreement in its facilities. It cites numerous concerns regarding use of the Standard Admission Agreement in CDVA facilities (specified in Comments 30.B-30.G), and states that the majority of the proposed Agreement is "contraindicated" for use in veterans homes.
Commenter: 916.6

Department Response:
DHS was not granted the authority under HSC §1599.60 et seq. to exempt certain departments or their licensed skilled nursing or intermediate care facilities from the requirements of the statute.

B. Comment: Preamble language asking residents to contact the State Long-Term Care Ombudsman to discuss the Standard Admission Agreement could create unnecessary confusion for veterans and their families, unless the Ombudsman is familiar with CFR Title 12 regulations governing admission to veterans homes. Also, it is unlikely that California Veterans Board policies governing admission to a veterans home could be incorporated into the Standard Admission Agreement.
Commenter: 916.1

Department Response:
The Department has revised the Standard Admission Agreement to reflect the appropriate role of the Ombudsman in the admission process – please see response to comment A.1. It is the Long-Term Care Ombudsman's role to represent individuals in licensed skilled nursing or intermediate care facilities, including those operated by the California Department of Veterans Affairs. CDVA should utilize current program flex provisions under HSC §1276 et seq. in order to accommodate the Standard Admission Agreement to its Board policies.

C. Comment: Preamble language specifying that the Standard Admission Agreement is the only document that must be signed as a condition of admission is not applicable for veterans homes. The CDVA requires additional documentation that assists staff in obtaining veterans benefits for residents. Also, as a matter of public policy, veterans homes are a cooperative venture with the federal government in providing a place of residence for veterans, and are referred to as "Veterans Homes, not 'nursing homes'" in the Military and Veterans Code.
Commenter: 916.2

Department Response:
Please refer to previous response regarding program flex. As noted in responses to Comments 16.B and 33.H; nothing in the proposed regulations precludes facilities from informing residents of their policies outside of the admission process. Veterans Homes, as skilled nursing or intermediate care facilities licensed by the Department of Health Services, are required under the mandates of HSC §1599.60 et seq., to adhere to the stipulations of Title 22 and to the Agreement.

D. Comment: Section II language regarding participation in Medi-Cal or Medicare advises both the resident and the resident's representative that they will not assume any personal liability for covering the cost of care if the facility participates in the Medi-Cal or Medicare programs. This conflicts with CDVA's Cost of Unreimbursed Care protocols, and with §1035.7 of the Military and Veterans Code related to cost of care for expenses in excess of fees for which members are responsible. Also, the Legislature may alter member fees at their discretion.
Commenter: 916.3

Department Response:
DHS disagrees that the Standard Admission Agreement conflicts with Military and Veterans Code protocols, which address "excess costs" not included in veterans' benefits, and believes these issues can be addressed under program flex. Please also refer to responses to Comments 12.A and 13.

E. Comment: Section V language regarding Financial Arrangements between a resident and provider facility are governed by §1012.3 of the Military and Veterans Code, which conflicts with standard financial arrangements the CDVA enters into with its residents, for example with regard to per diem grants for veterans.
Commenter: 916.4

Department Response:
DHS does not agree; please refer to previous response.

F. Comment: In contrast to the Standard Admission Agreement, CDVA policies for Medicare/Medi-Cal beneficiaries do not require that residents pay Medicare co-insurance if they do not have supplemental insurance (subject to Legislative discretion), and Medi-Cal recipients' share of costs are subtracted from their billings.
Commenter: 916.4

Department Response:
Please see response to Comment 12.A: DHS believes that share-of-cost issues have been adequately addressed in the Agreement. The CDVA may address specific veterans excess cost issues through program flex requests.

G. Comment: Section VI bed-hold provisions differ from that required by USDVA regulations regarding passes and leaves.
Commenter: 916.5

Department Response:
These issues can also be addressed through program flex.

31. General Comment: ISOR, p.4: "The proposed agreement... reflects general consensus about what the agreement should address."
Comment: In the ISOR the Department implies that there was a consensus among stakeholders regarding major provisions of the Standard Admission Agreement. Concurs that inclusion of a voluntary arbitration agreement in the Agreement was the major issue; however, Commenter's recollection of the last stakeholder meeting was a continuing lack of agreement on many of the proposals in the Agreement.
Commenters: 889.1; 896.1; 898.6; PH 4.2

Department Response:
The Department notes the concern, but respectfully disagrees. As acknowledged in the Initial Statement of Reasons, several areas of controversy remain in the proposed regulations, such as arbitration and freedom to contract. DHS has met with stakeholders interested in Standard Admission Agreement since April 1999, and has taken into consideration input from all interested parties throughout the process, both in writing and in public testimony, to address these issues and draft these regulations. As noted in this document, the Department has made numerous revisions to the proposed regulations in response to input from interested parties.

32. General Comment: Implementation of Standard Admission Agreement
A. Comment: Advocates for senior citizens strongly support implementation of the Standard Admission Agreement. They state that it should be finalized as soon as possible to minimize the perceived use of deceptive practices and exploitation of seniors by skilled nursing or intermediate care facilities, and that facilities should be required to use the Agreement both for incoming and existing residents. One commenter states that the agreements currently in use misrepresent the law and deprive residents of their rights under state and federal law. Implementation of the Agreement is the best way possible to correct these abuses and honor the intent of SB 1061, which required that the Agreement be in use by January 1, 2000.
Commenters: 894.16; 905.1; PH 3.1, 3.2, 3.4; PH 5.1, 5.9

Department Response:
The Department generally has no response to these informative comments, other than to reaffirm the mandate of SB 1061. However, the Agreement will be used only on a prospective basis, since there is no provision in law to implement regulations on a retroactive basis.

B. Comment: The Standard Admission Agreement is an important step forward in protecting the rights of California's most vulnerable citizens, and its implementation should not be further delayed.
Commenters: 902.1, 902.4; PH 1.7; PH 3.3

Department Response:
The Department respectfully acknowledges these comments.

C. Comment: Implementation of the Standard Admission Agreement under HSC §1599.61 et seq. is not only for consumer protection, but specifies the rights and responsibilities for every stay in a SNF/ICF for the foreseeable future.
Commenter: PH 2.1

Department Response:
The Department believes that it has conformed with all applicable state and federal requirements in drafting the proposed regulations for the Agreement.

D. Comment: Commenter's primary concern is that residents understand their rights, know what their charges will be, have a sense of what to expect regarding a facility and its care delivery systems, and have current information.
Commenter: PH 4.1

Department Response:
The Department concurs, and believes these goals are addressed in the Agreement.

33. Format of the Standard Admission Agreement: Concerns and recommendations regarding basic formatting guidelines.
A. Comment: Agreement should be withdrawn or revised because it is inconsistent, fails to follow the provisions of HSC §1599.60 et seq., lacks statutory authority and clarity, is not a regulatory requirement, is illegal, and misstates Patient's Rights.
Commenters: 896.23; 900.2; 913.4; 915.4; PH 2.2; PH 4.6, 4.8

Department Response:
DHS disagrees with these comments, and believes that it has followed the mandate set forth in the statutes. Responses to specific issues cited have been addressed elsewhere, specifically in responses to Comments 3.A, 3.B, 5.A, 5.B, and 9.A.

B. Comment: states the Agreement does not meet the basic practicalities of contracting to include the resident's name of the first page, and replacement of "Title" with "Relationship to Resident" on the third page.
Commenter: 898.13

Department Response:
The Department acknowledges the suggestions, and has made the requested changes (pp. 1,3 of the post-hearing document) of the Agreement.

C. Comment: Under each blank signature block in the Agreement an additional line should be added for the signer's printed name, since signatures may not be legible.
Commenter: 898.13

Department Response:
The Department does not agree with the necessity for this revision, since the resident's name is required to be typed or printed under Section II of the Agreement. From a practical standpoint, nothing in the regulations precludes notation of a resident's name on the Agreement, provided it does not alter or obscure the text.

D. Comment: The Department's use of plain language has resulted in misinterpretation of legal and regulatory requirements. States that the Standard Admission Agreement should use the exact wording, or adhere as closely as possible to the statute.
Commenter: PH 2.8, 2.10

Department Response:
The Department believes that it has conformed with all applicable statutes and regulations in drafting the Standard Admission Agreement.

E. Comment: the Standard Admission Agreement is a bad regulation, is poorly written and does not correctly represent current statutes; although it is shorter than that currently used by facilities, it is more complicated and incomprehensible.
Commenter: 889.5; 900.1; PH 4.9

Department Response:
DHS' goal in drafting a Standard Admission Agreement is that it be understandable for all California nursing facility residents or their representatives, while meeting the statutory mandates of HSC §1599.61.

F. Comment: the Agreement is not more complicated than the agreements currently used by facilities, which are complicated and convoluted, but is comprehensible for all users, and represents a huge improvement over what is currently in use. It lists statutory and regulatory requirements in contract terms, is legal, informs residents of their rights, and is fair to all parties in informing them of expectations.
Commenter: PH 5.2

Department Response:
The Department acknowledges the supportive comments.

G. Comment: Considerable work is necessary to clarify the new regulations. It should include only provisions that are required by statute to be in the Agreement, plus necessary contractual terms.
Commenters: 901.4; 913.4; 915.4, PH 2.2, 2.3; PH 5.6

Department Response:
The Department asserts that it has followed the mandates of the statutes, and all current state and federal legislation, in drafting the Standard Admission Agreement; please also see response to Comment 33.A. Additionally, DHS has addressed numerous specific concerns and made many changes to the Standard Admission Agreement in response to Commenters' suggestions.

H. Comment: For the Standard Admission Agreement to be lawful, it must permit facilities to add business terms. Another commenter seeks to attach additional exhibits to the Agreement for particular facility services.
Commenter: PH 2.5; 914.3

Department Response:
In response to numerous comments the Department has revised the Standard Admission Agreement substantially to include recommended contract language (see response to Comment 24.C), and facilities may use the program flex option to request other business terms or additional attachments they believe are required for their particular facility operations. (Please also see response to Comment 16.B.)

I. Comment: Inclusion of additional business terms would open the door to all sorts of individual provisions, and would subvert the intent of the statute.
Commenter: PH 5.8

Department Response:
The Department agrees that provisions specific to a particular facility should be added through the program flex option. Please note that DHS has modified the Standard Admission Agreement to add a number of commonly used legal terms (see Comment 24.C).

J. Comment: Many of the provisions of the Standard Admission Agreement are restatements of law, and including them in the Agreement turns violations of them into a breach of contract, which is unnecessary because the law already provides remedies for such violations. Recommends the Agreement be reduced to three parts: the contract, attachments, and an information packet.
Commenter: 911.3

Department Response:
The Department does not agree that it has overstepped its authority; it has followed the requirements of SB 1061 in drafting the regulations, to minimize perceived abuses of nursing facility admission practices, while complying with all state and federal laws and regulations related to facility operations. Regarding the recommendation, DHS has divided the Standard Admission Agreement into the contract and its attachments. There is nothing that precludes a facility from providing an additional information packet for a resident, provided that the Agreement is the only document signed as a condition of admission.

34. General Comment: The meaning of statutes has been altered, and federal law may not be utilized as statutory authority for a state regulation unless such law has been adopted by the state.
Comment: The Agreement alters the meaning of statutes, utilizes federal authority that has not been adopted by the state, and misstates or misrepresents state and federal authority. Examples cited include transfer and discharge provisions of the Agreement, liability of residents' representatives, patient's rights, obtaining Medi-Cal/Medicare information, and applicability of refund policies.
Commenters: 555-652; 712-888; 896.13, 896.23; PH 4.8

Department Response:
The Department disagrees with general comment, and believes it has complied with all state and federal statutory authority in drafting these regulations, in accordance with the requirements of SB 1061. Specific examples of inconsistent application of statutes are addressed elsewhere in this document, in this case in the responses to Comments 13, 9.A, 15.A-15.J, and 17.D.

Exhibit 4

FINAL STATEMENT OF REASONS

[Note: Bracketed, bold text contains a description and/or explanation of revisions to the text following the 45-day and 15-day comment periods.]

Chapter 631, Statutes of 1997, added Section 1599.61 to the Health and Safety Code (HSC) requiring all licensed skilled nursing and intermediate care facilities to use a standard admission agreement developed by the Department of Health Services, and requiring the Department to develop a comprehensive Patients' Bill of Rights. This legislation, authored by Senator Vasconcellos, expressed the following findings and declarations of the Legislature:

- Many nursing home admission agreements are unnecessarily long, complicated, and incomprehensible to consumers;
- It is in the best interests of nursing home residents that admission agreements meet standards required under state and federal law and that they not violate residents' rights;
- There is little uniformity among admission agreements and it is an unnecessary burden and expense to review all agreements for compliance with state and federal law; and,
- A uniform admission agreement would provide consistency, promote and protect residents' rights, and conserve state resources and funds.

The bill expressed the specific intent of the Legislature to mandate a standard admission agreement to be used for all admissions to all licensed skilled nursing facilities, intermediate care facilities, and nursing facilities in California.

Two points of terminology need clarification. First, the legislation refers to skilled nursing facilities, intermediate care facilities, and nursing facilities. Under California law, only "skilled nursing facilities" and "intermediate care facilities" are licensed facility types. "Nursing facilities" is a term defined in Section 1250(k) of the Health and Safety Code to mean a facility licensed pursuant to Division 2 Chapter 2 of the Health and Safety Code 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 (called Medi-Cal in California) under Title XIX of the federal Social Security Act, or as both.. Accordingly, since "nursing facilities" are "skilled nursing facilities" or "intermediate care facilities," regulatory action is only required to implement this legislation with regard to skilled nursing facilities and intermediate care facilities. A separate regulation for "nursing facilities" is not required.

Second, there has been an evolution in the term used to identify persons receiving care in skilled nursing or intermediate care facilities. Some provisions of law and

regulation refer to these persons as "patients" and some refer to the same persons as "residents". In fact, the legislation requiring adoption of a standard admission agreement uses both these terms interchangeably. Throughout this document and in the proposed regulations, the term "resident" is used to refer to persons receiving care in skilled nursing or intermediate care facilities, because that term is currently more commonly used (e.g., "Patient's Bill of Rights" becomes "Resident Bill of Rights").

The Department proposes to adopt two parallel regulation sections to implement the provisions of Section 1599.61 of the Health and Safety Code: Section 72516 applies the statutory requirements to skilled nursing facilities and Section 73518 applies statutory requirements to intermediate care facilities. "Skilled nursing facilities" which must use the Standard Admission Agreement are defined in Section 72103 of Title 22 of the California Administrative Code, and include both freestanding facilities and facilities which operate as a distinct part of a hospital. Section 73051 of Title 22 defines "intermediate care facilities" which must use the Standard Admission Agreement including both freestanding facilities and those that operate as a distinct part of a hospital. The specific purpose and rationale for each subsection of the proposed regulations is as follows:

Sections 72516, 73518, Subsection (a): This subsection requires the licensee to use the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, DHS Form Number HS 327 (02/05), which is incorporated by reference. The Department has determined that it will be more efficient and effective to incorporate the standard form by reference, rather than adopting regulations that specify format standards and specific language and requiring each facility to create its own form consistent with those standards. By adopting regulations that incorporate the form by reference, the Department can make available – in hard copy, in electronic format, and on the Internet – the specific form required for use by licensees. This is also consistent with the goals of the statutory mandate to promote uniformity of admission agreements, assure compliance with all state and federal requirements, and minimize associated administrative burden.

A discussion of the specific content of the California Standard Admission Agreement for licensed Skilled Nursing and Intermediate Care Facilities follows this discussion of the text of the proposed regulations.

[Sections 70516(a) and 73518(a) of Title 22 were amended to change the date of DHS Form Number HS 327 (incorporated by reference in these regulations), which has been amended in response to 45-day public notice and 15-day public availability comments received by the Department.]

Sections 72516, 73518, Subsection (b): This subsection prohibits any alteration of the standard admission agreement by the licensee without prior written approval from the Department, except that information specific to the facility or the resident may be entered in spaces provided in the standard admission agreement form. HSC Section 1599.61(b)(1) contains the prohibition that "No facility shall alter the standard agreement unless so directed by the department," in order to ensure that the admission agreement is not arbitrarily altered by the licensee, and that only the standard agreement adopted by the Department is used. On the other hand, HSC §1276(b) requires "regulations shall permit program flexibility ... as long as statutory requirements are met and the use has the prior written approval of the department." This provides the opportunity for a licensee to request, and the Department to approve, facility-specific program flexibility in the standard agreement in order to meet unique circumstances as long as all statutory requirements are met.

Though not specifically addressed by statute, allowing the entry of information specific to a facility and a resident is essential from a practical perspective. The California Standard Admission Agreement must offer the flexibility to identify the specific parties to the contract and to accommodate legitimate differences among facilities, such as available optional services and related prices.

Sections 72516, 73518, Subsection (c): This subsection provides that no resident or their representative can be required to sign any other document at the time of, or as a condition of, admission to the facility, or as a condition of continued stay in the facility. This is consistent with HSC §1599.60(b) which defines a contract of admission as including all documents which must be signed by the resident or his or her representative at the time of, or as a condition of, admission. This protects residents against the possibility that documents other than the standard admission agreement might be represented to them as documents that require their signature as a condition of admission. On the other hand, this provision does not preclude facilities from discussing other documents (such as selection of a pharmacy), and presenting those documents to prospective residents for their voluntary signature, as long as those documents are clearly separate from the admission agreement and are not presented as a condition of admission.

While HSC §1599.60(b) does not specifically provide that the admission agreement is the only document that must be signed "as a condition of continued stay in the facility," the Department proposes to include this language to prevent potential confusion and possible misrepresentation of documents to residents for signature after their admission. Inclusion of this phrase is simply a clarifying statement of fact. Failure to sign any specific document after admission is not included in state or federal law or regulation, or in the proposed California Standard Admission Agreement (Section VI. Transfers and Discharges), as a legitimate reason for involuntary discharge from a facility. Since failure to sign any document after admission is not a legitimate reason

for involuntary discharge, then no document other than the standard admission agreement must be signed as a condition of continued stay in the facility.
Sections 72516, 73518, Subsection (d): This subsection prohibits the inclusion of an arbitration agreement as part of the California Standard Admission Agreement. This provision is based on the following interpretation of the Health and Safety Code:

- Section 1599.60 defines "contract of admission" to include "all documents which a resident or his or her representative must sign at the time of, or as a condition of, admission to a long-term health care facility";
- While Section 1599.81(a) and (d) allow an arbitration clause to be included in a contract of admission, no provision of law requires inclusion of an arbitration clause therein nor does any provision of law require that an arbitration agreement be signed at the time of admission;
- Section 1599.81(a) mandates that "All contracts of admission that contain an arbitration clause shall clearly indicate that agreement to arbitration is not a precondition for medical treatment or for admission to the facility";
- Section 1599.81(b) provides that "all arbitration clauses shall be included on a form separate from the rest of the admission contract."

Accordingly, an arbitration agreement: 1) need not be signed as a condition of admission; 2) if present, must be separate from the contract of admission; and 3) is not otherwise mandated by statute to be included within the standard admission agreement. Therefore, an arbitration agreement cannot be presented to prospective residents as though it were part of the standard admission agreement. This proposed subsection does not prohibit the use of arbitration agreements; rather, it requires that any arbitration agreement be separate from the standard admission agreement.

Subsection (d) also requires that any arbitration agreement must contain a prominently placed advisory in bold-face font of not less than 12 point type, as follows: "**Residents are not required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights.**" This provision implements the intent of HSC §1599.81(a) that residents be clearly notified that agreement to arbitration is not a precondition for admission, and HSC §1599.81(d) requiring notice to residents that they may not waive the ability to sue for violation of the Resident Bill of Rights. Section 123222.1 of the Health and Safety Code requires that admission papers and forms, as well as certain other documents, used by skilled nursing and intermediate care facilities must be printed in at least 12 point type that is clear and legible.

During the course of developing this regulation package, the Department received a petition requesting the adoption of regulations to implement the standard admission agreement requirements of §1599.61 of the Health and Safety Code. The Department's response to the petition was published in the California Regulatory

Notice Register on January 28, 2000. The petition and DHS response are in the rulemaking file for this proposed regulatory action.

[It should be noted that in its 15-day public notice document, the Department proposed amendments to 22CCR Sections 70503 and 70627, to exempt Distinct Part/Skilled Nursing Facilities (DP/SNFs) and Distinct Part Intermediate Care Facilities (DP/ICFs) that are Supplemental Services of a hospital from the requirements of SB 1061.

In making this revision to the proposed regulations, DHS reasoned that the Standard Admission Agreement was not applicable to DP/SNFs or DP/ICFs because they are not licensed as skilled nursing or intermediate care facilities, but are sub-units of a different type of licensed healthcare facility. Additionally, residents of such facilities have already completed admission agreements for those facilities.

However, following further legal and policy review, and in response to comments received in the 15-day public notice availability, DHS has determined that the Standard Admission Agreement should apply to residents of all nursing facilities in California, including DP/SNFs and DP/ICFs, because HSC §1599.61(a) requires its use by all facilities as defined under HSC §1250(c) (Skilled Nursing Facilities), HSC §1250(d) (Intermediate Care Facilities), and HSC §1250(k) (Nursing Facilities). Also, as noted in the Initial Statement of Reasons, "Skilled Nursing Facilities" are defined under 22CCR 72103 to include both freestanding facilities and facilities that operate as a distinct part of a hospital, and 22CCR 73051 defines "Intermediate Care Facilities" to include both freestanding facilities and those that operate as a distinct part of a hospital. The Department is authorized, under HSC §1275, to develop regulations governing all such facilities.

Historically DP/SNFs and DP/ICFs were regulated by DHS as part of a licensed hospital facility. For the reasons stated above, the Department has now determined that these facilities are required to be held to the mandates of §1599.61 et seq. Please refer to response to Comment 29 of Addendum II, and responses to Comments 2.A – 2.F of Addendum IV, for further discussion of these issues.]

(Please also note that numeric cross-references to Comments refer to Addendum II or Addendum IV, and any changes to the Standard Admission Agreement reflect revisions to the original documents published on May 28, 2004, with the Initial Statement of Reasons, unless otherwise noted.)

California Standard Admission Agreement:

Since the enactment of Health and Safety Code §1599.61, the Department has met extensively with long term care facility representatives and consumer representatives

to discuss the development of a standard admission agreement. The content of the proposed agreement, though not the specific language, to a large extent reflects a general consensus about what the agreement should address. There were two areas in which consensus could not be reached: 1) inclusion of a reference to arbitration agreements within the standard agreement itself and attachment of an arbitration agreement thereto, and 2) whether a standard admission agreement represented an unconstitutional abridgement of the "freedom of contract."

With respect to arbitration, the proposed standard admission agreement contains no mention of arbitration and provides no attachment to accommodate an arbitration agreement. The rationale for the Department's determination in this regard is presented in the Initial Statement of Reasons discussion regarding "Subsection d" of the proposed regulation text.

With respect to the constitutional argument, the Department is prohibited by Article III, Section 3.5 of the California Constitution from declaring a statute unconstitutional and from refusing to enforce a statute. In addition, the Department has attempted to provide for expected and appropriate variances among facilities by providing spaces to record facility-specific terms and including templates as attachments to record different services and related charges. The Department has attempted to craft a standard admission agreement that complies with all applicable state and federal laws, as required by Health and Safety Code §1599.61(a).

Each section of the California Standard Admission Agreement (Agreement) is discussed below, with a brief justification for the inclusion of each sentence or group of sentences with the same purpose. *Agreement language is indicated in underline and italics.* All references to the Health and Safety Code are abbreviated "HSC", all references to Title 22 of the Code of California Regulations are abbreviated "22CCR", and all references to Title 42 of the Code of Federal Regulations are abbreviated "42CFR."

Resident Name: _____

Admission Date: _____ ***Resident Number:*** _____

Facility Name: _____

[This addition to the Agreement was made in response to Comment 33.B of Addendum II, to add the names of the parties to the first page of the Agreement.]

CALIFORNIA STANDARD ADMISSION AGREEMENT FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

I. Preamble

The Preamble provides general information to introduce the prospective resident to the nature of the document.

The California Standard Admission Agreement is an admission contract that this Facility is required by state law and regulation to use.

This informs the resident that the facility must use this document as its admission agreement, consistent with the provisions of HSC §1599.61 and these proposed regulations.

[Non-substantive changes were made by the Department to clarify the formal name of the Agreement.]

It is a legally binding agreement that defines the rights and obligations of each person (or party) signing the contract.

This acknowledgement makes it clear that the admission agreement is a legal document defining the rights and obligations of persons signing the agreement. The parenthetical inclusion of the phrase "or party" simply serves to introduce this common contracting term to the resident as meaning the same thing as "person signing the contract."

Please read the agreement carefully before you sign it. If you have any questions, please discuss them with Facility staff before you sign the agreement. You are encouraged to have this contract reviewed by your legal representative, or by any other advisor of your choice, before you sign it.

This is an important advisory to prospective residents, to the effect that they should carefully review, and be satisfied with their understanding of, the contract before signing it. HSC §1599.65 imposes on facilities the duty to make reasonable efforts to communicate the content of the contract to the prospective resident.

[This section was revised in response to Comment 1.B of Addendum II, to eliminate an inadvertent responsibility placed on Facility staff to ensure that Residents understand the Agreement.]

You may also call the Office of the State Long Term Care Ombudsman at 1-800-231-4024, for more information about this Facility.

This sentence advises the prospective resident that additional information is available from the office of the State Long Term Care Ombudsman, a state agency whose purpose is to provide this kind of help. HSC 1599.85 requires that all contracts of admission contain the following advisory: "For more information about our facility, you may call the State Ombudsman's Office at (insert toll free number)." The language proposed for the standard admission agreement is not identical to that required by statute; however, it achieves the same purpose. The minor changes in language are intended to more accurately identify the State Ombudsman's Office by using its complete title, and to inform the resident that he/she may call the Ombudsman's Office to obtain more information about the facility.

[This sentence was revised in response to Comment 1.A of Addendum II, to remove an inadvertent expansion of Ombudsman's responsibilities, which are specified in statute. Also, a non-substantive change was made to eliminate a redundant reference to "a toll-free number."]

Reports of state inspections of this Facility are posted _____, and a copy may be obtained from the local office of the California Department of Health Services (DHS), Licensing and Certification Division.

This sentence advises prospective residents that the findings of inspections performed by the Licensing and Certification Division of the Department of Health Services, are available in the facility and from the local office of the Licensing and Certification Division. HSC §1599.87 requires the Department to develop a list of approximately 25% of long term care facilities with the most serious records of violations. This HSC Section also requires facilities on this list to include the following specific statement on their contracts of admission: "This facility's record of citations is posted at the facility, and a copy may be obtained from the Department of Health Services." However, this statutory requirement predates the requirement that the Department develop a standard admission agreement for use by all skilled nursing and intermediate care facilities. In order to develop a standard agreement for use by all of these facilities (75% of which would not be required to carry this advisory in their admission agreement) and recognizing the Legislature's intent that prospective residents be advised in the admission agreement that information about licensing inspections is available, the Department proposes to include this sentence. 22CCR 72503 requires facilities to conspicuously post in a prominent location accessible to the public the "Most recent licensing visit report supported by the related follow-up plan of correction visit reports." Accordingly, this provision of the standard admission agreement

imposes no new requirement and meets the Legislative intent that prospective residents be advised that information about licensing inspections is available to them.

[This sentence was revised in response to Comment 6.A of Addendum II, to allow Facilities to insert information regarding posting of State inspections.]

If you are able to do so, you are required to sign this Agreement in order to be admitted to this Facility. If you are not able to sign this Agreement, your representative may sign it for you. You shall not be required to sign any other document at the time of, or as a condition of, admission to this Facility.

These sentences simply advise the resident that he or she must sign the admission agreement in order to be admitted to the facility, but no other document is required to be signed. This is consistent with the definition of "contract of admission" contained in HSC §1599.60(b), including "all documents which a resident ... must sign", and with HSC §1599.65(a), which provides that "the facility shall make reasonable efforts to ... obtain on the contract the signature of the person who is to be admitted to the facility." HSC §1599.65(a) further provides that, "In the event the patient [resident] is unable to sign the contract, the reason shall be documented in the resident's medical record by the admitting physician." Accordingly, the law allows for admission to a facility when neither the resident nor a representative acting on the resident's behalf signs the admission agreement.

II. Identification of Parties to this Agreement

In order to make this Agreement more easily understood, references to "we", "our", "us", "the Facility", or "our Facility" are references to:

_____

(Insert the Name of the Facility as it appears on its License)

References to "you", "your", "Patient," or "Resident" are references to

_____*, the person who will be receiving care in this Facility.*

In these sentences, the Department expresses its intent to make this admission agreement an easily understood document, in part by using personal pronouns in referring to the parties to the agreement. Although not specifically required by law, contracts often contain provisions that formally identify the parties and introduce plain language terms that will be used in the contract when referring to one or the other of those parties. Note that federal or state laws and regulations use the terms "Resident" and "Patient" interchangeably.

[A phrase explaining the use of personal pronouns was removed as a non-substantive change by the Department to eliminate non-essential language.]

The parties to this agreement are the Resident, the Facility, and the Resident's Representative. References to the ***"Resident's Representative"*** *are references to: _____, the person who will sign on your behalf to admit you to this Facility, and/or who is authorized to make decisions for you in the event that you are unable to. To the extent permitted by law, you may designate a person as your Representative at any time.*

Note: the person indicated as your ***"Resident's Representative"*** *may be a family member, or by law, any of the following: a conservator, a person designated under the Resident's Advance Directive or Power of Attorney for Health Care, the Resident's next of kin, any other person designated by the Resident consistent with State law, a person authorized by a court, or, if the Resident is a minor, a person authorized by law to represent the minor.*

HSC §1599.65 uses several terms to identify persons who may act on the resident's behalf, including "legal representative", "responsible party", and "agent", but these terms are not defined in statute. This definition of Resident's Representative is drawn from 22CCR 72527(d), which specifies who may act as a Resident's Representative as follows: "Persons who may act as the patient's [resident's] representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's [resident's] valid durable power of attorney for health care, patient's [resident's] next of kin, other appropriate surrogate decision-maker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient [resident] is a minor, a person lawfully authorized to represent the minor."

[This section was modified in response to Comment 13 of Addendum II, to specify the responsibilities of a Resident's Representative. Also, it should be noted the phrase *"To the extent permitted by law,"* was added to the last sentence of the first paragraph, in response to a 15-day availability comment (Addendum IV, Comment 12.A), This non-substantive change was made by the Department to recognize the relevance of current law to all Agreement provisions, and to conform Agreement language with Consent to Treatment provisions in Section III.]

Any Resident's Representative who signs this Agreement on your behalf assumes no PERSONAL financial liability for your care provided by this Facility.

This provision advises both the resident and the resident's representative, that a resident's representative, by signing this agreement on the resident's behalf, does not assume personal responsibility for covering the cost of care for the resident. If the resident's representative has legal control of the income and assets of the resident (for example, as a conservator), then that representative has the authority and separate legal responsibility to use the resident's assets and income to pay for the costs of care provided to the resident -- but that representative has no personal financial liability. The signature of the resident's representative on this document only acknowledges, on behalf of a resident who cannot do so for him or herself, that the representative understands the contents of the agreement and agrees to abide by its terms.

[This sentence was modified in response to Comment 13 of Addendum II, to emphasize and clarify the responsibilities of a Resident' s Representative.]

IF OUR FACILITY PARTICIPATES IN THE MEDI-CAL OR MEDICARE PROGRAM, OUR FACILITY DOES NOT REQUIRE THAT YOU HAVE ANYONE GUARANTEE PAYMENT FOR YOUR CARE BY SIGNING OR COSIGNING THIS ADMISSION AGREEMENT AS A CONDITION OF ADMISSION.

HSC §1599.65(b) requires that a contract of admission for facilities participating in Medi-Cal "set forth, in bold capital letters ... the prohibition ... that no facility may require or solicit as a condition of admission that a Medi-Cal beneficiary have a responsible party sign or cosign the contract of admission." DHS' interpretation of the Legislative intent of this provision was to prohibit facilities from requiring that someone sign or cosign the admission agreement as the person responsible for making payments to the facility on the resident's behalf. This interpretation is reasonable since the State of California, via the Medi-Cal program, is the guarantor of payment for Medi-Cal beneficiaries. Further, 42CFR 483.12(d)(2) provides that no facility certified for participation in Medicare or Medi-Cal may "require a third party guarantee of payment to the facility as a condition of admission." On the other hand, a facility that does not participate in Medi-Cal or Medicare may require a financial guarantor, which would be a separate compensation agreement with the guarantor and could involve a person other than the resident or his or her representative.

[This sentence was modified in response to Comment 15.A of Addendum II, to remove a misstatement of federal law related to financial guarantees.]

The Parties to this Agreement are:

Resident: _____.
(Type or Print Resident's Name Here)

Resident's Representative: _____.
(Type or Print Representative's Name Here)

Relationship: _____.

Facility: _____.
(Enter the Facility's Name as it appears on the License)

This provision is not required by state law to be included in the admission agreement. However, the Department has determined that it is consistent with standard practice to include specific identification of the parties to this contract.

[This section was modified in response to Comment 33.B of Addendum II, to more accurately identify the Resident' s Representative.]

III. **Consent to Treatment**

The Resident hereby consents to routine nursing care provided by this Facility, as well as emergency care that may be required.

This sentence expresses the resident's consent to the nursing care that the facility is licensed to provide, and emergency care if it may be needed. HSC §1599.72 provides that "Contracts of admission may require consent only for routine nursing care or emergency care" and that "no contract of admission shall include a clause requiring residents sign a consent to all treatment ordered by a physician." The proposed agreement language is consistent with these provisions of law.

[This non-substantive change was made by the Department to make the Agreement more concise.]

However, you have the right, to the extent permitted by law, to refuse any treatment and the right to be informed of potential medical consequences should you refuse treatment. We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and services we provide you.

HSC §1599.72 requires that the admission contract contain a clause that informs the resident of the right to refuse treatment, consistent with the provisions of 22CCR 72527(a)(4). While not specifically required by law, the Department proposes to

include language which reflects the provisions of 22CCR 72527(a)(5), regarding the resident's right to be fully informed regarding a decision to accept or refuse treatment. Further, 22CCR 72528 details informed consent obligations of facilities toward their residents.

[This section was modified in response to Comments 7.A, 8.A, and 28 of Addendum II, to conform more closely with the requirements of federal and state statutes and regulations, and to accommodate those situations where a person is involuntarily admitted to a Facility for court-mandated care.]

If you are, or become, incapable of making your own medical decisions, we will follow the direction of a person with legal authority to make medical treatment decisions on your behalf, such as a guardian, conservator, next of kin, or a person designated in an Advance Health Care Directive or Power of Attorney for Health Care.

This sentence advises prospective residents that, if they are not able to make medical decisions on their own, specified other persons may act on their behalf. Although not specifically required by law, this provision is important so that both the facility and the resident know how medical decisions will be made if the resident cannot make them, and is consistent with 22CCR 72527(d). Further, HSC §1418.8 specifies how the determination of a resident's capacity to make medical decisions is to be ascertained and recorded, and how those medical decisions are to be made if the resident is incapable of making them.

[This sentence was modified in response to Comment 7.C of Addendum II, to conform more closely to the requirements of state statutes and regulations.]

Following admission, we encourage you to provide us with an Advance Health Care Directive specifying your wishes as to the care and services you want to receive in certain circumstances. However, you are not required to prepare one, or to provide us a copy of one, as a condition of admission to our Facility. If you already have an Advance Health Care Directive, it is important that you provide us with a copy so that we may inform our staff.

If you do not know how to prepare an Advance Directive and wish to prepare one, we will help you find someone to assist you in doing so.

This paragraph advises prospective residents that they may also express their treatment preferences through an Advance Directive. HSC §1599.73 provides that "After admission, the facility shall encourage residents having the capacity to make health care decisions to execute an advance health care directive ... " Accordingly, neither the preparation of an Advance Directive, nor the provision of a copy of one,

can be a condition of admission to the facility. On the other hand, residents are advised here that, if they do have an Advance Directive, they should provide it to the facility. As noted, HSC §1599.73 requires facilities to encourage residents to prepare an Advance Directive if they do not already have one. It also provides for notifying the Long-Term Care Ombudsman of newly admitted residents in this regard.

[This section was modified in response to Comments 7.A and 7.C of Addendum II, to clarify the extent of Facilities' responsibilities under HSC §1599.73, and to encourage Residents to prepare Advance Health Care Directives, in conformance with state laws and regulations.]

IV. Your Rights as a Resident

Residents of this Facility keep all their basic rights and liberties as a citizen or resident of the United States when, and after, they are admitted. Because these rights are so important, both federal and state laws and regulations describe them in detail, and state law requires that a comprehensive Resident Bill of Rights be attached to this Agreement.

This paragraph introduces residents to the fact that they lose no rights by virtue of their admission to the facility. In fact, they are advised that state and federal laws and regulations describe specific rights in detail. HSC §1599.61(d) requires that the Department develop a comprehensive resident bill of rights, and that this bill of rights be included as an attachment to the admission agreement.

[This sentence was modified in response to Comments 9.A of Addendum II, to more clearly state Resident rights. The word "summary" was not changed at the time of the post-hearing changes to Attachment A, Resident Bill of Rights and the phrase "summary of them" was later replaced by "Resident Bill of Rights" as a non-substantive change that accurately describes Attachment A in its current form.]

***Attachment A**, entitled "Resident Bill of Rights", lists your rights as set forth in State and Federal law. For your information, the attachment also provides the location of your rights in statute.*

This paragraph directs residents to Attachment A to find the comprehensive list of resident rights.

[This paragraph was modified in response to Comments 9.A et seq. of Addendum II, to list Resident rights as stated in federal and state statute and regulations. Please see page 35 of this document for further discussion.]

Violations of state laws and regulations identified above may subject our Facility and our staff to civil or criminal proceedings. You have the right to voice grievances to us without fear of any reprisal, and you may submit complaints or any questions or concerns you may have about our services or your rights to the local office of the California Department of Health Services, Licensing and Certification District Office _____, or to the State Long-Term Care Ombudsman (see page 1 for contact information)..

The Department has expanded the advisory with respect to residents' ability to submit complaints to the Department of Health Services or the State Long-Term Care Ombudsman, and to provide residents with contact information of the Department's nearest Licensing and Certification District Office.

[This advisory was modified in response to Comment 6.B of Addendum II, and to provide residents with specific Department and Ombudsman contact information, in accordance with HSC §1599.75(c).]

You should review the attached "Resident Bill of Rights" very carefully. To acknowledge that you have been informed of the "Resident Bill of Rights," please sign here: _____.

This language advises the prospective resident to review the bill of rights carefully, and requests written acknowledgement that the resident has been informed of his or her rights. HSC §1599.74(c) requires that the admission agreement "contain a separate written acknowledgement that the resident has been informed of the Patient's [Resident] Bill of Rights. Written acknowledgement by the resident or the resident's representative must be made either on a separate document or in the admission agreement itself next to the clause informing the resident of these regulatory rights. Written acknowledgement by use of the signature on the agreement as a whole does not meet this requirement." The Department considered the option of including this acknowledgement on Attachment A, Resident Bill of Rights, as allowed by law. The decision to place the written acknowledgement here is intended to call residents' particular attention to these important rights early in their review of this agreement. As well, the Resident Bill of Rights is a document that the Department intends to circulate widely to the public, and everyone receiving this document need not acknowledge receipt – only persons who are being admitted to a facility are required to acknowledge receipt of this information.

V. Financial Arrangements

Beginning on _____ (date), we will provide routine nursing and emergency care and other services to you in exchange for payment.

Our Facility has been approved to receive payment from the following government insurance programs: ***Medi-Cal*** ***Medicare***

At the time of admission, payment for the care we provide to you will be made by:

_____ ***Resident (Private Pay)***
_____ ***Medi-Cal***
_____ ***Medicare Part A*** ***Medicare Part B***
_____ ***Private Insurance:*** _____
(Enter Insurance Company Name and Policy Number)
_____ ***Managed Care Organization:*** _____
_____ ***Other:*** _____

This provision of the agreement is not specifically required by law: however, it is very important for both the facility and the resident to clearly understand and agree how the facility will be paid for the care provided to the resident.

[This section was modified in responses to Comments 8.A and 14.A of Addendum II, to conform with Section III revisions and to provide additional payor classification categories.]

Resident's Share of Cost. *Medi-Cal, Medicare, or a private payor may require that the Resident pay a co-payment, co-insurance, or a deductible, all of which the Facility considers to be the Resident's share of cost. Failure by the Resident to pay his or her share of cost is grounds for involuntary discharge of the Resident.*

[This section was added in response to Comment 12.A of Addendum II, to address residents' payment responsibilities.]

If you do not know whether your care in our Facility can be covered by Medi-Cal or Medicare, we will help you get the information you need.

This provision is not specifically required by law: however, federal regulations (42CFR 483.10(b)(10)) do require that facilities that participate in Medicare or Medi-Cal must assist residents in determining whether they qualify for benefits under these programs. Accordingly, this requirement only applies to facilities certified for participation in Medicare or Medi-Cal.

[A non-substantive change was made by the Department to make this section more concise. Please refer to Comment 15.B, Addendum II, for further discussion.]

You should note that, if our Facility does not participate in Medi-Cal or Medicare and you later want these programs to cover the cost of your care, you may be required to leave our Facility.

This provision is simply an advisory to residents who may be considering admission to a facility that is not certified for Medi-Cal or Medicare participation that, should they later want to take advantage of the benefits provided by these government programs, they may be required to leave the facility – since the facility is not eligible to receive payments from either program.

[APPLICABLE ONLY IF DATE IS ENTERED:] *On _____ (date) our Facility notified the California Department of Health Services of our intent to withdraw from the Medi-Cal Program. If you are admitted after that date, we cannot accept Medi-Cal reimbursement on your behalf, and we will not be required to retain you as a Resident if you convert to Medi-Cal reimbursement during your stay here. If, on the other hand, you were a Resident here on that date, we are required to accept Medi-Cal reimbursement on your behalf, even if you become eligible for Medi-Cal reimbursement after that date.*

[This paragraph was added to the Standard Admission Agreement in responses to Comment 15.C of Addendum II, to provide residents with additional information about a facility's Medi-Cal participation (if applicable).

Also, the Department has inserted "*[APPLICABLE ONLY IF DATE IS ENTERED:]*" to this paragraph in response to Comments 4.A-C of Addendum IV. DHS considers this to be a change to the clause made to add clarity to its meaning, without regulatory effect.]

YOU SHOULD BE AWARE THAT NO FACILITY THAT PARTICIPATES IN THE MEDI-CAL PROGRAM MAY REQUIRE ANY RESIDENT TO REMAIN IN PRIVATE PAY STATUS FOR ANY PERIOD OF TIME BEFORE CONVERTING TO MEDI-CAL COVERAGE. NOR, AS A CONDITION OF ADMISSION OR CONTINUED STAY IN SUCH A FACILITY, MAY THE FACILITY REQUIRE ORAL OR WRITTEN ASSURANCE FROM A RESIDENT THAT HE OR SHE IS NOT ELIGIBLE FOR, OR WILL NOT APPLY FOR, MEDICARE OR MEDI-CAL BENEFITS.

[The last sentence was added by the Department to complete the advisory by notifying residents of their non-waiver rights regarding Medicare/Medi-Cal benefits, as stated in federal and state laws and regulations.]

HSC §1599.69(a) requires several notifications that must be included in all admission agreements and must be presented in "bold capital letters of not less than 10-point type." The first requirement is notification that no resident "may be required to pay privately for any period during which the resident has been approved for payment by Medi-Cal." The second required notification is that "the facility shall return any and all payments made by the beneficiary ... for Medi-Cal program covered services upon receipt of Medi-Cal payment." The third required notification is that "no certified facility may require as a condition of admission ... that residents remain in private pay status for a specified period of time." This proposed paragraph of the standard admission agreement provides the last of these three notifications. The proposed location of this advisory flows in logical sequence in this introductory discussion of payment arrangements. It should be noted here that the 10-point type requirement was superseded by the adoption of HSC §123222.1, which requires use of at least 12-point type in a variety of documents (including admission papers). The 14-point format of the proposed agreement meets both of these statutory standards. The last sentence is an advisory to residents of rights regarding Medicare and Medi-Cal benefits that cannot be waived, as stated in 42CFR 483.12(d)(1)(i), and logically completes the notification regarding residents' rights to these programs.

A. Charges for Private Pay Residents

Our Facility charges the following basic daily rates:

$ _____ for a private, single bed room

$ _____ for a room with two beds

$ _____ for a room with three beds

$ _____ for _____
(Specify any other accommodation here)

The basic daily rate for private pay and privately insured Residents includes payment for the services and supplies described in ***Attachment B-1.***

This portion of the admission agreement specifies the daily rate that will be charged to a resident who is paying for his or her own care out of personal resources and describes the nursing services that are covered under the daily rate. HSC §1599.67(a) requires that every contract of admission "state clearly what services and supplies are

covered by the facility's basic daily rate." In order to accommodate appropriate differences between facilities with respect to what services and supplies are covered by the basic daily rate, Attachment B-1 is a standard template for facilities to list those services and supplies covered by the basic daily rate.

The basic daily rate will be charged for the day of admission, but not for any day beyond the day of discharge or death. However, if you are voluntarily discharged from the Facility less than three days after the date of admission, we may charge you for a maximum of three days at the basic daily rate.

This provision is essential for both the facility and the resident to know and agree on when the requirement for payment starts and stops. HSC §1599.71(a) provides that no admission contract "shall require the resident to pay for days beyond the date of his or her death or involuntary discharge, except that a facility may charge a resident for a maximum of three days at the basic daily rate in the event that the resident is voluntarily discharged from the facility less than three days following his or her admission." The Department's interpretation of Legislative intent regarding this provision is that no resident should be charged for any day after voluntary discharge, unless the stay in the facility was for less than three days.

We will provide you with a 30-day written notice before increasing the basic daily rate, unless the increase is required because the state increases the Medi-Cal rate to a level higher than our regular rate. In this case, state law waives the 30-day notification.

HSC §1599.67(c) requires that every contract of admission clearly state that the facility is required to "provide no less than 30 days written notice ... of any increase ... in the daily room rate, except as provided in subdivision (b) of Section 1288." The exception allowed in HSC §1288(b) relates to the fact that facilities are prohibited by law from charging the Medi-Cal program a daily rate that is higher than the daily rate charged to private pay residents. When Medi-Cal payment rates change as a result of emergency regulations or are made retroactive, the facility has no advance notice of the change in Medi-Cal rates. This precludes the possibility of providing 30-days notice to residents and, if the exception were not available, the facility would be unable to bill Medi-Cal at the newly adopted Medi-Cal rate since private pay rates would then be lower than the newly adopted Medi-Cal rate.

***Attachment B-2** lists for private pay and privately insured Residents optional supplies and services not included in our basic daily rate, and our charges for those supplies and services. We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. We will provide you a 30-day written notice before any increase in charges for optional supplies and services.*

If you become eligible for Medi-Cal at any time after your admission, the services and supplies included in the daily rate may change, and also the list of optional supplies and services. At the time Medi-Cal confirms it will pay for your stay in this Facility, we will review and explain any changes in coverage.

HSC §1599.67(a) requires that the admission agreement specify in detail which services are optional, and the charges for these services. The Department proposes to meet this requirement in the context of this standard admission agreement by referring to an attached standard template that each facility must fill out listing the optional services the facility makes available to residents if they wish to pay for them and the prices charged.

State law does not specifically require that facilities must charge residents only for optional supplies and services that the resident specifically requests. However, the Department believes that this is a reasonable requirement, one, which does apply to all facilities certified for participation in Medi-Cal or Medicare. 42CFR 483.10(c)(8)(iii) provides "The facility must not charge a resident ... for any item or service not requested by the resident." Further, it is essential for the facility and the resident to have a clear agreement on this point so that: a) the facility does not provide services, and charge the resident for them, if the resident has not requested them, and b) the resident does not expect the facility to provide optional services the resident has not requested.

HSC §1599.67(c) requires "30 days written notice to the residents of any increase for optional services or in the daily room rate charged." While the Legislature did not specify that this notice requirement applies to increases in charges for optional supplies, it did specify that the notice applies to increases in charges for optional services. The Department believes it is a reasonable interpretation that the Legislature intended that 30-day notice be given for any increase in charges for optional supplies, as well as for services.

HSC §1599.67(b) requires that admission agreements for facilities that participate in Medi-Cal or Medicare indicate that optional and covered services may be different for residents in those programs than for private pay residents. It also requires that, when a resident converts to Medi-Cal coverage, the facility must give the resident a form listing Medi-Cal optional and covered services.

[This section was modified in response to Comment 14.A of Addendum II, and to clarify payment arrangements and charges outside the daily rate for private pay residents.]

B. Security Deposits

If you are a private pay or privately insured Resident, we require a security deposit of $_____.

We will return the security deposit to you, with no deduction for administration or handling charges, within 14 days after you close your private account or we receive payment from Medi-Cal.

State law does not prohibit facilities from collecting a security deposit from private pay or privately insured residents. Accordingly, a security deposit may be required for such residents, and this part of the standard agreement allows the facility and the resident to negotiate and record a mutually agreeable security deposit. HSC §1599.70(b) requires that "any security deposit from a person paying privately upon admission shall be returned within 14 days of the private account being closed, or first Medi-Cal payment, whichever is later, and with no deduction for administration or handling charges."

If your care in our Facility is covered by Medi-Cal or Medicare, no security deposit is required.

[This section was moved and reordered to place it more appropriately in the text of the Agreement, and revised in response to Comment 17.A of Addendum II, to eliminate inappropriate stipulations for private pay deposits.]

C. Charges for Medi-Cal, Medicare, or Insured Residents

IF YOU ARE APPROVED FOR MEDI-CAL COVERAGE AFTER YOU ARE ADMITTED TO OUR FACILITY, YOU MAY BE ENTITLED TO A REFUND. WE WILL REFUND TO YOU ANY PAYMENTS YOU MADE FOR SERVICES AND SUPPLIES WHICH ARE LATER PAID FOR BY MEDI-CAL, LESS ANY DEDUCTIBLE OR SHARE OF COST. WHEN OUR FACILITY RECEIVES PAYMENT FROM THE MEDI-CAL PROGRAM, WE WILL ISSUE A REFUND TO YOU.

As noted above, HSC §1599.69(a) requires several notifications to be included in all admission agreements. The second required notification is that "the facility shall return any and all payments made by the beneficiary ... for Medi-Cal program covered services upon receipt of Medi-Cal payment."

[This section was moved to more appropriately place the language in the Agreement.]

If you are entitled to benefits under Medi-Cal, Medicare, or private insurance, and if we are a participating Provider, we agree to accept payment from them for our basic daily rate.

This provision is not required by statute to be included in the admission agreement. However, the facility will have already agreed to accept payment from these programs by virtue of the fact that they participate in one or all of the programs. It is an essential term of the contract that both the facility and the resident agree that payments from these programs will be accepted by the facility in lieu of payment by the resident.

[This section has been renumbered in the Agreement.]

NEITHER YOU NOR YOUR REPRESENTATIVE SHALL BE REQUIRED TO PAY PRIVATELY FOR ANY MEDI-CAL COVERED SERVICES PROVIDED TO YOU DURING THE TIME YOUR STAY HAS BEEN APPROVED FOR PAYMENT BY MEDI-CAL. UPON PRESENTATION OF THE MEDI-CAL CARD OR OTHER PROOF OF ELIGIBILITY, THE FACILITY SHALL SUBMIT A MEDI-CAL CLAIM FOR REIMBURSEMENT.

As noted above, this is one of the three notifications required to be included in the admission agreement, pursuant to HSC §1599.69(a). It is more appropriately located here, rather than with the other two notifications addressed above, because this part of the contract deals with charges for Medi-Cal eligible residents.

[The second sentence was added to the Agreement language after the post-hearing change 15-day public availability to conform it with the requirements of HSC §1599.69; as a restatement of law it constitutes a change without regulatory effect.]

However, you are still responsible for paying all deductibles, copayments, coinsurance, and charges for services and supplies that are not covered by Medi-Cal, Medicare, or your insurance. Please note that our Facility does not determine the amount of any deductible, copayment, or coinsurance you may be required to pay; rather, Medi-Cal, Medicare, or your insurance carrier determines these amounts.

These sentences are not required by law to be included in the admission agreement. However, they are statements of fact and it is essential that both the facility and the resident agree that charges that are not covered by a governmental or private insurer must be paid by the resident. They also serve to avoid confusion for residents who, because they are eligible for government benefits or have private insurance, might think that they will not be required to pay anything for the care provided by the facility.

[This section has been renumbered in the Agreement, and modified in response to Comments 13 and 14.B of Addendum II, to clarify resident's and representative's payment options and responsibilities.]

Attachments C-1, C-2, and C-3 *describe the services covered by the Medi-Cal daily rate, services that are covered by Medi-Cal but are not included in the daily rate, and services that are not covered by Medi-Cal but are available if you wish to pay for them.*

Attachments D-1 and D-2 *describe the services covered by Medicare, and services that are not covered by Medicare but are available if you wish to pay for them.*

The preceding two sentences implement the requirements of HSC §1599.67 that contracts of admission clearly identify the services and supplies that are covered under the daily rate and those that are optional, along with the prices charged for optional supplies and services. Attachments C-1 and C-2 were provided by the Medi-Cal program to describe services and supplies covered under the daily rate and other supplies and services that are covered by the Medi-Cal program but not under the daily rate. Attachment C-3 is a standard template that must be completed by each facility, listing the additional supplies and services that that particular facility makes available to Medi-Cal eligible residents if they wish to pay for them. Attachment D-1 describes the services covered by the Medicare program. Attachment D-2 is a standard template, which must be completed by each facility, listing those supplies and services that that particular facility makes available to Medicare residents if they wish to pay for them.

You should note that Medi-Cal will only pay for covered supplies and services if they are medically necessary. If Medi-Cal determines that a supply or service is not medically necessary, we will ask whether you still want that supply or service and if you are willing to pay for it yourself.

Though not required by statute to be included in the admission agreement, this is an important advisory to avoid confusion for Medi-Cal residents. The Medi-Cal program maintains a process for determining the medical necessity of covered benefits and, if a benefit is not medically necessary, Medi-Cal will not pay for it. For example, Medi-Cal may determine that an electric wheelchair is not medically necessary for a resident and that a manual wheelchair will meet the resident's medical needs. In that case, Medi-Cal will not pay for the electric wheelchair. This provision requires the facility to inform the resident of the Medi-Cal determination that an otherwise covered supply or service is not medically necessary and determine whether the resident wishes to purchase that supply or service with their own resources. This is consistent with 42CFR 483.10 (c)(8)(iii) which provides "The facility must not charge a resident ... for any item or service not requested by the resident."

[This section has been renumbered in the Agreement, and modified in response to Comments 15.E and 15.F of Addendum II, to clarify resident's and representative's payment options and responsibilities.]

We will only charge you for optional supplies and services that you specifically request, unless the supply or service was required in an emergency. We will provide you a 30-day written notice before any increase in charges for optional supplies and services.

State law does not specifically require that facilities must charge residents only for optional supplies and services that the resident specifically requests. However, the Department believes that this is a reasonable requirement, one, which does apply to all facilities certified for participation in Medi-Cal or Medicare. 42CFR 483.10(c)(8)(iii) provides that "The facility must not charge a resident ... for any item or service not requested by the resident." Further, it is essential for the facility and the resident to have a clear agreement on this point so that: a) the facility does not provide services, and charge the resident for them, if the resident has not requested them, and b) the resident does not expect the facility to provide optional services the resident has not requested.

These two sentences are identical to provisions discussed under Subsection A, and are duplicated here to clarify that residents who have Medi-Cal, Medicare, or private insurance will only be charged for optional supplies and services that they request and will be given appropriate notice of any change in charges for those supplies and services.

[This section was revised in response to Comments 13, 15.E and 15.F of Addendum II, to acknowledge situations when a physician orders supplies or services for a resident. It should also be noted that in its 15-day post-hearing availability changes DHS erroneously included the phrase *"or your physician"* in the sentence "*We will only charge you for optional supplies and services that you or your physician specifically request, unless the supply or service was required in an emergency."* The corrected sentence (with the phrase "or your physician" deleted) mirrors identical language in the Financial Arrangements, Section A provision for private pay residents in the Agreement.]

D. Billing and Payment

We will provide to you an itemized statement of charges that you must pay every month.

HSC §1599.67(a) requires that "Every contract of admission ... indicate that residents will receive monthly statements itemizing all charges incurred by them."

[This sentence was revised in response to Comment 19 of Addendum II, to remove irrelevant language from the Agreement.]

You agree to pay the account monthly on _____ (enter day of month).

This sentence is not required by statute to be included in the admission agreement and there is no specific statutory requirement that residents pay monthly, or at all, for supplies and services provided by the facility and not covered by government or private insurance. However, by requiring the facility to provide a monthly-itemized statement, it follows that the Legislature expected residents to pay the account monthly. This is an essential term of the contract in order for the facility to have a contractual basis for timely collection of reimbursements from residents for services provided.

Payment is overdue _____ days after the due date. A late charge at an interest rate of _____% is charged on past due accounts and is calculated as follows:

_____

_____

HSC §1599.68 requires that "Any long-term health care facility that imposes interest on delinquent accounts shall clearly state in the contract of admission the rate of interest so charged and the method of computation. To meet this statutory requirement, since there are no statutory or regulatory definitions of "delinquent accounts," it is essential that both the facility and the resident specifically agree about when payment becomes past due. Similarly, since there are no statutory or regulatory standards regarding interest rates for past due accounts or the method for calculating late charges, the agreement must provide flexibility for the facility and the resident to negotiate and record these terms of the contract.

E. Payment of Other Refunds Due To You

As indicated in Section V.C above, refunds may be due to you as a result of Medi-Cal paying for services and supplies you had purchased before your eligibility for Medi-Cal was approved or for any security deposit you may have made. At the time of your discharge, you may also be due other refunds, such as unused advance payments you may have made for optional services not covered by the daily rate. We will refund any money due to you within 14 days of your leaving our Facility. We will not deduct any administration or handling charges from any refund due to you.

This provision is not required by state law to be included in the admission agreement, nor does state law specifically apply the requirement for payment of refunds within 14 days and prohibition of deduction for administrative expenses to any refund other than a security deposit refund. However, since there may be other refunds due to the

resident and this contract should address any standards for payment of such refunds, the Department believes it is a reasonable interpretation of Legislative intent that any and all refunds due to the resident be paid by the facility according to the specific terms adopted by the Legislature for refunds of security deposits. As well, 22CCR 72531 requires that any advance rental payments be returned to the resident or their representative no later than two weeks after the resident's discharge or death.

[The change of the cross-reference "Section V. A and D" to "Section V. C" is a non-substantive change necessitated by the reorder of language in Section V.]

VI. Transfers and Discharges

You may leave our Facility at any time without prior notice to us. We will help arrange for your voluntary discharge or transfer to another facility.

HSC §1599.71(b) provides "no contract of admission shall require advance notice of voluntary discharge from a facility." 22CCR 72433(b)(5) requires all licensed facilities to provide "Discharge planning for each patient [resident] and implementation of the plan."

Except in an emergency, we will not transfer you to another room within our Facility, or to another facility, and we will not discharge you from our Facility against your wishes unless we give prior written notice to you.

HSC §1599.78 provides "All contracts of admission shall state that except in an emergency, no resident may be involuntarily transferred within or discharged from a long-term health care facility unless he or she is given reasonable notice in writing ..."

The only reasons that we can transfer or discharge you against your wishes are:

1) *It is required to protect your well-being, because your needs cannot be met in our Facility;*

2) *It is appropriate because your health has improved enough that you no longer need the services of our Facility;*

3) *Your presence in our Facility endangers the health and safety of other individuals;*

4) *You have not paid for your stay in our Facility or have not arranged to have payment made under Medicare, Medi-Cal, or private insurance;*

5) *Our Facility ceases to operate;*

6) *Material or fraudulent misrepresentation of your finances to us.*

HSC §1599.76(a) provides that "No contract of admission shall list any ground for involuntary transfer or discharge of the resident except those grounds that are specifically enumerated in either federal or state law." 42CFR 483.12(a)(2) lists reasons #1 through #5 above as the only reasons a certified facility may transfer or discharge a resident, and HSC §1439.7 specifies conditions under which reason #6 may be invoked to transfer or discharge a resident.

[This section was revised in response to Comment 10.A of Addendum II, and to reorder text for enhanced clarity. The Department also eliminated unnecessary language.

Also, it should be noted that in its 15-day post-hearing change availability, the Department deleted misrepresentation of finances as a condition (reason #6) for involuntary transfer. Following legal review, DHS determined that reason #6 is required to be included in the Standard Admission Agreement, in conformance with the requirements of HSC §1439.7 and HSC §1599.76. The Department does not have the authority to choose not to enforce these standards, based on the requirements of Section 3.5, Article 3 of the Constitution. Please see Addendum 2, response to Comment 10.A for further discussion of this issue.]

If we participate in Medi-Cal or Medicare, we will not transfer or discharge you from the Facility solely because you change from private pay to Medicare or Medi-Cal payment.

HSC §1599.76(b) provides that "Every contract of admission to a long-term health care facility that participates in the Medi-Cal program shall state that the facility may not transfer or seek to evict any resident solely as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal." However, WIC §14124.7(c) allows a facility to transfer a resident within a facility because of a change in resident's healthcare needs or if the bed retention would result in no available Medicare-designated beds within a facility, and 42CFR 483.12(a)(1) states that a transfer means from one certified facility to another.

[This section was changed in response to Comment 10.E of Addendum II, to clarify requirements for Transfers and Discharges.]

Our written notice of transfer or discharge against your wishes will be provided 30 days in advance. However, we may provide less than 30 days notice if the reason for the transfer or discharge is to protect your health and safety or the health and safety of

other individuals, if your improved health allows for a shorter notice, or if you have been in our Facility for less than 30 days. Our written notice will include the effective date, the location to which you will be transferred or discharged, and the reason the action is necessary.

As noted above, HSC §1599.78 requires "reasonable notice in writing". It also requires that the "notice shall state the reason for the transfer or discharge." In this Agreement, the Department is defining "reasonable notice" in a manner consistent with federal regulations which apply to facilities certified for participation in Medi-Cal or Medicare. 42CFR 483.12(a)(4), (5), and (6) require written notice at least 30 days before the resident is transferred or discharged, except in specified circumstances, and require the notice to include the reason, the effective date, and the location to which the resident will be transferred. The 30-day requirement is also consistent with HSC §1336.2(c), which requires a 30-day written notice to residents if they must be transferred due to any change in the status of the license or the operation of the facility such that the facility can no longer care for the residents.

[This paragraph was moved to more appropriately place notice requirements for Transfers and Discharges in the Agreement.]

In our written notice, we will advise you that you have the right to appeal the transfer or discharge to the California Department of Health Services, Licensing and Certification Division, and we will also provide the name, address and telephone number of the State Long-Term Care Ombudsman.

As noted above, 42CFR 483.12(6) specifies the content of a written notice of transfer or discharge. In addition to the effective date, reason, and location to which the resident will be transferred, this federal regulation requires the notice to include "A statement that the resident has the right to appeal the transfer or discharge to the State," and "The name, address and telephone number of the State long term care ombudsman." The Department has determined that it is appropriate to include this information in the "reasonable notice" required by statute, since it provides the resident with contact information if they have concerns with a proposed involuntary transfer or discharge.

[The addition of "California" is a non-substantive change made to correctly identify the Department for enhanced clarity of the Agreement.]

If you are transferred or discharged against your wishes, we will provide transfer and discharge planning as required by law.

HSC §1599.78 provides that "All contracts of admission shall state that except in an emergency, no resident may be involuntarily transferred within or discharged from a

long-term health care facility unless he or she is given ... transfer or discharge planning as required by law."

[This change was made in response to Comment 10.l of Addendum II, to conform with the requirements of HSC §1599.78.]

VII. Bed Holds and Readmission

If you must be transferred to an acute hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you.

HSC §1599.79 requires that contracts of admission meet the requirements of 22CCR 72520. That section imposes no requirements with respect to admission agreements, but rather establishes bed hold standards. However, since the Legislature included this provision in a section of law that deals with admission agreement content requirements, the Department concluded that the Legislature intended that specific information about bed hold standards be included in admission agreements. Accordingly, these two sentences are included to reflect requirements in HSC §1599.79 that facilities "offer to hold a bed for the resident in the event the resident must be transferred to an acute care hospital for seven days or less" and that "the resident or the representative for the resident has 24 hours from receipt of the notice to request the bedhold."

If Medi-Cal is paying for your care, then Medi-Cal will pay for up to seven days for us to hold the bed for you.

HSC §1599.79 requires that "the facility shall inform the resident that Medi-Cal will pay for up to seven bedhold days." While not specifically required to be included in the admission agreement, its inclusion in this part of the admission agreement is consistent with the Department's conclusion that the Legislature intended that such information be included in the contract of admission and this location of the information within the agreement follows logically from the previous notifications.

If you are not eligible for Medi-Cal and the daily rate is not covered by your insurance, then you are responsible for paying $ _____ for each day we hold the bed for you. You should be aware that Medicare does not cover costs related to holding a bed for you in these situations.

These sentences are not required by statute to be included in the admission agreement. However, having informed prospective residents that if they are eligible for Medi-Cal then Medi-Cal will pay for up to seven bedhold days, it is necessary to advise residents who are not eligible for Medi-Cal that, as provided in 22CCR 72520

(a)(2), they are liable to pay bedhold charges unless they are a covered benefit under another insurance program. To minimize possible resident confusion in this regard, the factual statement that Medicare does not cover bedhold charges is also included.

If we do not follow the notification procedure described above, we are required by law (Title 22 California Code of Regulations Sections 72520(c) and 73504(c)) to offer you the next available appropriate bed in our Facility.

HSC §1599.79 requires that "the contract of admission shall state that the facility shall offer the next available appropriate bed to the resident in the event the facility fails to follow this required procedure."

[The Department revised this advisory in the Agreement as a non-substantive, post-hearing change to more accurately reflect the requirements of HSC §1599.79 and state regulations.]

You should also note that, if our Facility participates in Medi-Cal and you are eligible for Medi-Cal, if you are away from our Facility for more than seven days due to hospitalization or other medical treatment, we will readmit you to the first available bed in a semi-private room if you need the care provided by our Facility and wish to be readmitted.

This provision is not required by state law to be included in the admission agreement. However, 42CFR 483.12(b)(3) does impose this requirement on certified facilities and the Department believes it is appropriate to include this provision here in the admission agreement to provide a complete description of readmission provisions.

[This change was made in response to Comment 11 of Addendum II, to conform with federal regulations.]

VIII. Personal Property and Funds

Our Facility has a theft and loss prevention program as required by state law. At the time you are admitted, we will give you a copy of our policies and procedures regarding protection of your personal property, as well as copies of the state laws that require us to have these policies and procedures.

These sentences are not required by state law to be included in the admission agreement. However, because of the importance of this issue to prospective residents, the Department has determined that it is appropriate to advise prospective residents in the admission agreement that state law requires facilities to have theft and

loss prevention programs. HSC §1418.7 requires facilities to have theft and loss prevention programs that meet specific standards. HSC §1289.4 also imposes various requirements regarding a facility's responsibility to protect residents' personal property, and subdivision (l) requires that a facility's policies and procedures regarding theft and loss prevention be provided to new residents upon admission.

If our Facility participates in Medi-Cal or Medicare and you give us your written authorization, we will agree to hold personal funds for you in a manner consistent with all federal and state laws and regulations. If we are not certified for Medi-Cal or Medicare, we may offer these services but are not required to. You are not required to allow us to hold your personal funds for you as a condition of admission to our Facility. At your request, we will provide you with our policies, procedures, and authorization forms related to our holding your personal funds for you.

These provisions are not required by state law to be included in the admission agreement. However, because of the importance of this issue to prospective residents, the Department has determined that it is appropriate to advise prospective residents regarding personal fund management services. 42CFR 483.10(c) requires certified facilities to provide personal fund management services and establishes standards for such services. 22CCR 72529 also establishes standards for safeguarding residents' personal funds.

IX. Photographs

You agree that we may take photographs of you for identification and health care purposes. We will not take a photograph of you for any other purpose, unless you give us your prior written permission to do so.

This provision is not required by state law to be included in the admission agreement. However, HSC §1599.80 allows facilities to photograph residents only for identification and health care purposes and provides that photographs for any other purpose must be authorized in advance "on a document separate from the admission agreement as a whole." Accordingly, the Department has determined that it is the intent of the Legislature that residents be required to consent to being photographed for identification or health care purposes within the admission agreement, since photographs are such an important element in assuring resident security and provision of appropriate care.

X. Confidentiality of Your Medical Information

You have a right to confidential treatment of your medical information. You may authorize us to disclose medical information about you to a family member or other person by completing the "Authorization for Disclosure of Medical Information" form in

Attachment E.

HSC §1599.73 requires that "every contract of admission shall state that residents have a right to confidential treatment of medical information," and "the contract shall provide a means by which the resident may authorize the disclosure of information to specific persons, by attachment of a separate sheet."

XI. Facility Rules and Grievance Procedure

You agree to comply with reasonable rules, policies and procedures that we establish. When you are admitted, we will give you a copy of those rules, policies, and procedures, including a procedure for you to suggest changes to them.

A copy of the Facility grievance procedure, for resolution of resident complaints about Facility practices, is available; we will also give you a copy of our grievance procedure for resolution of any complaints you may have about our Facility. You may also contact the following agencies about any grievance or complaint you may have:

[In the second paragraph, the first sentence was changed after the post-hearing change 15-day public availability, to conform the Agreement language with the requirements of HSC §1599.75(b); as a restatement of law it constitutes a change without regulatory effect.]

California Department of Health Services
Licensing and Certification District Office
Phone number: _____

(OR)

State Long-Term Care Ombudsman Program
Phone number: _____

HSC §1599.75 requires that the contract of admission: a) indicate that any rules adopted by a facility which must be observed by a resident must be reasonable; b) specify that a copy of the facility's grievance procedure is available; and, c) inform residents of their right to contact the Department of Health Services or the long-term care ombudsman. The appropriate entity within the Department for residents to contact is the local district office of the Licensing and Certification Division. Space is

provided for the facility to enter the phone number of these two entities to facilitate resident contact with either or both of them if a need to do so arises. HSC §1599.61 (b)(3) allows facilities to distribute written explanations of facility-specific rules and procedures, but prohibits the inclusion of such written materials in the admission agreement.

XII. Entire Agreement

This Agreement and the Attachments to it constitute the entire Agreement between you and us for the purposes of your admission to our Facility. There are no other agreements, understandings, restrictions, warranties, or representations between you and us as a condition of your admission to our Facility. This Agreement supersedes any prior agreements or understandings regarding your admission to our Facility.

This provision is not required by statute to be included in the admission agreement. However, it is very important that both the facility and the resident know and agree that the contents of this admission agreement are the only terms and conditions of admission to the facility and that no other representations or understandings can be enforced as though they were a part of this contract of admission.

[The phrase "with respect to" was changed to "for the purposes of" in the first sentence of the language identified above as a non-substantive post-hearing change. The word "regarding" was replaced by the phrase "as a condition of" in the second sentence to conform with the proposed regulations Sections 72516(c) and73518(c). These non-substantive changes were made for enhanced clarity.]

All captions and headings are for convenience purposes only, and have no independent meaning.

If any provision of this Agreement becomes invalid, the remaining provisions shall remain in full force and effect.

The Facility's acceptance of a partial payment on any occasion does not constitute a continuing waiver of the payment requirements of the Agreement, or otherwise limit the Facility's rights under the Agreement.

This Agreement shall be construed according to the laws of the State of California.

Other than as noted for a duly authorized Resident's Representative, the Resident my not assign or otherwise transfer his or her interests in this Agreement.

[These revisions were made in response to Comment 24.C of Addendum II, to add commonly used legal terminology to the Agreement.]

Upon your request, we shall provide you or your legal representative with a copy of the signed agreement, all attachments and any other documents you sign at admission and shall provide you with a receipt for any payments you make at admission.

[This change was made in response to Comment 24.B of Addendum II.]

By signing below, the Resident and the Facility agree to the terms of this Admission Agreement:

Representative of the Facility	*Date*
Resident	*Date*
Resident's Representative – if applicable	*Date*

This provision is not required by statute to be included in the admission agreement. However, it is essential and consistent with standard practice that the parties to a contract have an appropriate space to indicate their agreement to the contract by placement of their signatures or the signatures of authorized representatives.

Attachment A: Resident Bill of Rights

HSC §1599.61(d) requires that the Department develop a consolidated and comprehensive Resident Bill of Rights. It also requires that this Resident Bill of Rights be a mandatory attachment to all contracts of admission.

In developing the "Resident Bill of Rights" which is proposed as Attachment A to the Standard Admission Agreement, the Department compiled statutory and regulatory rights defined in HSC Chapter 3.9 (commencing with Section 1599), 22CCR 72527, 22CCR 73523, and 42CFR 483.10 et sequitur. The Department included as an Addendum certain additional regulations that were referred to in the above document, including 22CCR 72018, 22CCR 72528, 22CCR 72529, HSC §1320, WIC §4502 et seq., and WIC §5325 et seq. Attachment A provides specific references to relevant state law and regulation, and to federal regulation.

[In its 15-day post-hearing availability changes to Resident Rights, and in response to comments received (Addendum II, Comments 9.A et seq.) the Department elected to revise Attachment A to include resident rights in their entirety, including provisions contained in HSC Chapter 3.9, commencing with §1599, 22CCR §§72527 and 73523, and 42CFR 483.10 et seq. As also discussed in the response to Comments 7.A-7.B of Addendum IV, inclusion of these rights was mandated by SB 1061. The Department has no discretion but to follow the statutory mandate.

In the text of the 15-day post-hearing changes made available for public comment, DHS inadvertently omitted from the comprehensive rights 42CFR 483.12, 483.13, and 483.15, which also reference or directly refer to resident rights under federal regulations. Following review, the Department has restored those rights in Attachment A, consistent with the mandates of HSC §1599.6(d). DHS makes this change to the text of the regulations, which is deemed to be non-substantive and without regulatory effect, pursuant to 1CCR 100(a)(6), and which is not subject to the rule-making process as specified in Article 5 of the Administrative Procedures Act.

Finally, in response to Addendum IV, Comment 7.C, the Department has deleted from Attachment A of the 15-day public availability documents, as a non-substantive change, all sections of statutes and regulations that do not directly express resident rights or are not identified as resident's rights that are not specifically required by HSC §1599.6(d).]

[Please also note that the citation for 22CCR §73523 on page 2 of Attachment A was erroneously cited as "22CCR §73527" in the 15-day public availability documents; this error has been corrected.]

Attachment B-1: Supplies and Services Included in the Basic Daily Rate for Private Pay and Privately Insured Residents

Attachment B-2: Optional Supplies and Services Not Included in Basic Daily Rate for Private Pay and Privately Insured Residents

Attachments B-1 and B-2 are necessary to meet the Legislative mandate of HSC §1599.67(a) that "Every contract of admission shall state clearly what services and supplies are covered by the facility's basic daily rate" and that "the agreement shall specify in detail which services are optional, and the charges for these services ..." These two attachments do not impose any new requirements, nor do they otherwise interpret or make specific statutory mandates. They simply provide a standard template for facilities to use as required by HSC §1599.67 and allow for essential flexibility among facilities with respect to available services and pricing for private pay or privately insured residents.

Attachment C-1: Supplies and Services Included in the Basic Daily Rate for Medi-Cal Residents

Attachment C-2: Supplies and Services NOT Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider For Separately

These two attachments reflect the content of 22CCR 51123, 51321, and 51511, which define the services covered under the Medi-Cal Program. Attachment C-1 is required pursuant to HSC §1599.67. Attachment C-2 is not specifically required by statute. However, the Department has determined that is important to advise prospective Medi-Cal residents not only regarding what supplies and services are covered under the Medi-Cal basic daily rate and what optional services they may purchase with their own resources, but also that Medi-Cal covers a wide range of medical care services that are not paid for in the Medi-Cal daily rate, but that Medi-Cal will pay for. The attachments do not impose any new requirements, nor do they otherwise interpret or make specific statutory standards – they simply describe Medi-Cal covered services.

Attachment C-3: Optional Supplies and Services Not Covered By Medi-Cal That May Be Purchased By Medi-Cal Residents

This attachment is necessary to meet the legislative mandate of HSC §1599.67. It is a standard template on which each facility can record the optional supplies and services, and their respective prices, available for direct purchase by Medi-Cal residents. This list of optional supplies and services may be different from the list

recorded on Attachment B-2 since the supplies and services covered by the Medi-Cal program, either under the basic daily rate or otherwise, may be different from the supplies and services covered under the private pay daily rate or covered under a resident's private insurance. This attachment allows for essential flexibility among facilities with respect to the availability and pricing of optional supplies and services that may be purchased by Medi-Cal residents. It does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

Attachment D-1: Supplies and Services Covered by the Medicare Program For Medicare Residents

This attachment contains information excerpted from the brochure, "Your Medicare Benefits", which is published by the federal Centers for Medicare and Medicaid Services. This attachment is necessary since HSC §1599.67 requires a description of supplies and services covered under the Medicare basic daily rate, and those may differ from the supplies and services covered by the basic daily rate for private pay, privately insured, or Medi-Cal residents. Attachment D-1 is not as detailed as Attachments C-1 and C-2, because the Department was unable after an extensive search to find comparably detailed descriptions of Medicare coverage published by the federal government and the Department has no authority itself to define Medicare benefits. This attachment is merely descriptive and does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

Attachment D-2: Optional Supplies and Services Not Covered by Medicare That May Be Purchased By Medicare Residents

This attachment is necessary to meet the legislative mandate of HSC §1599.67, and is a standard template on which each facility can record the optional supplies and services, and their respective prices, available for direct purchase by Medicare residents. This list of optional supplies and services may be different from the list recorded on Attachments B-2 or C-3 since the supplies and services covered by the Medicare program, either under the basic daily rate or otherwise, may be different from those covered under the private pay daily rate, covered under a resident's private insurance, or covered by the Medi-Cal program. This attachment allows for essential flexibility among facilities with respect to the availability and pricing of optional supplies and services that may be purchased by Medicare residents.

Attachment E: Authorization for Disclosure of Medical Information

As noted earlier, this attachment is required pursuant to HSC §1599.73, which requires that "The contract shall provide a means by which the resident may authorize

the disclosure of information to specific persons, by attachment of a separate sheet that conforms to the specifications of Section 56 of the Civil Code." Section 56 of the Civil Code simply provides that "This part may be cited as the Confidentiality of Medical Information Act." However, the Department has determined that the Legislature clearly intended that the authorization required by HSC §1599.73 conform to all the provisions of the Confidentiality of Medical Information Act. Civil Code Section 56.11 prescribes the requirements for a valid authorization for disclosure of medical information. Among other things, the authorization must be in at least 8-point type, be clearly separate from other language and executed by a signature which serves no other purpose than to execute the authorization, be signed by the resident or resident's representative, and state:

- "the specific uses and limitations on the types of medical information to be disclosed,"
- "the name or functions of the provider of health care ... that may disclose the medical information,"
- "the name or functions of the persons or entities authorized to receive the medical information,"
- "the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information,"
- "a specific date after which the provider of health care ... is no longer authorized to disclose the medical information," and
- that "the person signing the authorization" has "the right to receive a copy of the authorization."

Proposed Attachment E is a form developed by the Department to conform to the standards set in Civil Code Section 56.11. It does not impose any new requirements, nor does it interpret or otherwise make specific any statutory mandates.

S276545

IN THE SUPREME COURT
OF THE
STATE OF CALIFORNIA

CHARLES LOGAN

Plaintiff and Respondent,

vs.

COUNTRY OAKS PARTNERS, LLC, et al.

Defendants and Appellants.

On Review From The Court Of Appeal For the Second Appellate District, Division Four, 2nd Civil No. 20STCV26536

After An Appeal From the Superior Court For The State of California, County of San Francisco, Case Number , Hon.

DECLARATION OF MARK E. REAGAN

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Attorneys for [Proposed] Amicus Curiae *California Association of Health Facilities*

I, Mark E. Reagan, declare as follows:

1. I am an attorney duly licensed to practice law in the State of California. I am an attorney with the law firm of Hooper, Lundy & Bookman, P.C., counsel of record for proposed *amicus curiae* California Association of Health Facilities ("CAHF") herein. The facts stated herein are personally known to me, and if called as a witness I could and would competently testify to them. I make this declaration in support of proposed *amicus curiae* CAHF's Request For Judicial Notice by Proposed *Amicus Curiae* California Association Of Health Facilities in Support Of Defendants-Appellants ("RJN").

2. I was the lead attorney for the plaintiffs in *Parkside Special Care Center, Inc., et al v. Shewry, et al.* (Super. Ct. San Diego County, 2006, No. GIC860574) ("*Parkside*"). CAHF was also one of the plaintiffs in *Parkside*.

3. The California Department of Health Services (the "Department") lodged true and correct copies of the rulemaking files for California Code of Regulations, title 22, sections 72516 and 73518 (collectively, "Section 72516") as the administrative record in *Parkside.* The California Department of Public Health ("CDPH") was formerly known as the California Department of Health Services, which was reorganized into the CDPH and the Department of Health Care Services.

4. **Exhibit 1** of the RJN is a true and correct copy of the Table

of Contents for CD and Hard Copies of Rulemaking File and Navigation Guide, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01, Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities (June 8, 2006), submitted by the Department on June 9, 2006. (Exhibit 1 of RJN at p. 2.)

5. **Exhibit 2** of the RJN is a true and correct copy of excerpts from the Initial Statement of Reasons, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 16, 2004), submitted by the Department on June 9, 2006. (*Ibid.*)

6. **Exhibit 3** of the RJN is a true and correct copy of excerpts from Addendum II – Summaries and Response to the Comments Received During the Public Comment Period, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 25, 2005), submitted by the Department on June 9, 2006. (*Ibid.*)

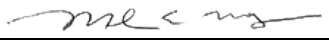
7. **Exhibit 4** of the RJN is a true and correct copy of excerpts from the Final Statement of Reasons, Department of Health Services, Office of Regulations, Rule-Making File for R-05-01 (April 29, 2005), submitted by the Department on June 9, 2006. (*Ibid.*)

8. **Exhibits 1, 2, 3, and 4** were not subject to judicial notice by the trial court or Court of Appeal because CAHF was not a party to the case at the trial court and not an amicus curiae at the Court of Appeal. Therefore, CAHF could not have produced Exhbits 1, 2, 3 and 4 to the trial

court or Court of Appeal.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on this 31 day of May, 2023, at San Francisco, California.



Mark E. Reagan

S276545

IN THE SUPREME COURT
OF THE
STATE OF CALIFORNIA

CHARLES LOGAN

Plaintiff and Respondent,

vs.

COUNTRY OAKS PARTNERS, LLC, et al.

Defendants and Appellants.

On Review from the Court of Appeal for the Second Appellate District, Division Four, Case No. B312967

After an Appeal from the Superior Court for the State of California, (Los Angeles County Super. Ct. No. 20STCV26536)

[PROPOSED] ORDER

The Court grants the California Association of Health Facilities' ("CAHF's") motion and takes judicial notice of the following documents attached to CAHF's Request for Judicial Notice:

- Exhibit 1
- Exhibit 2
- Exhibit 3
- Exhibit 4

DATED: _____, 202_

_____
Justice of the California Supreme Court

PROOF OF SERVICE

Logan v. Country Oaks Partners, LLC
Case No. S276545

STATE OF CALIFORNIA, COUNTY OF SAN FRANCISCO

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of San Francisco, State of California. My business address is 44 Montgomery Street, Suite 3500, San Francisco, CA 94104.

On May 31, 2023, I served true copies of the following document(s) described as **REQUEST FOR JUDICIAL NOTICE BY PROPOSED *AMICUS CURIAE* CALIFORNIA ASSOCIATION OF HEALTH FACILITIES IN SUPPORT OF DEFENDANTS-APPELLANTS; DECLARATION OF MARK E. REAGAN; [PROPOSED] ORDER** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: I caused the document(s) to be enclosed in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and the envelope to be placed for collection and mailing, following our ordinary business practices. I am readily familiar with the practice of Hooper, Lundy & Bookman, P.C. for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid. The envelope was placed in the mail at San Francisco, California.

BY ELECTRONIC SERVICE: I electronically filed the document(s) with the Clerk of the Court by using the TrueFiling system. Participants in the case who are registered users will be served by the TrueFiling system. Participants in the case who are not registered users will be served by mail or by other means permitted by the court rules.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on May 31, 2023, at San Francisco, California.

/s/ Diana Morgan
Diana Morgan

SERVICE LIST
Logan v. Country Oaks Partners, LLC
Case No. S276545

Through TrueFiling:
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Via Regular Mail
Clerk of the Court for
Hon. Monica Bachner
111 North Hill Street
Los Angeles, CA 90012

Through TrueFiling:
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Second Appellate District
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STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **LOGAN v. COUNTRY OAKS PARTNERS**
Case Number: **S276545**
Lower Court Case Number: **B312967**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **mreagan@hooperlundy.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
REQUEST FOR JUDICIAL NOTICE	Logan RJN Declaration and Proposed Order

Service Recipients:

Person Served	Email Address	Type	Date / Time
Julieta Echeverria Sun Mar Management Services	jecheverria@sunmarhealthcare.com	e-Serve	5/31/2023 5:09:32 PM
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This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

5/31/2023

Date

/s/Mark Reagan

Signature

Reagan, Mark (143438)

Last Name, First Name (PNum)

Hooper, Lundy & Bookman, P.C.

Law Firm