**Report to the**
**Colorado General Assembly**

# Hospice and Palliative Care Interim Committee

*Prepared by*

*The Colorado Legislative Council*
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# Hospice and Palliative Care Interim Committee

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December 2009

To Members of the Sixty-seventh General Assembly:

Submitted herewith is the final report of the Interim Committee to Study Hospice and Palliative Care. This committee was created pursuant to House Joint Resolution 09-1017. The committee is charged with considering barriers and disincentives that prohibit or prevent patients from receiving hospice and palliative care during chronic and life-threatening illnesses.

At its meeting on November 10, 2009, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2010 session was approved.

Respectfully submitted,

/s/ Senator Brandon Shaffer
Chair

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***This report is also available on line at:***

***http://www.colorado.gov/lcs/HospiceandPalliativeCare***

# Executive Summary

## Committee Charge

Pursuant to House Joint Resolution 09-1017, the Interim Committee to Study Hospice and Palliative Care was charged with considering barriers and disincentives that prohibit or prevent patients from receiving hospice and palliative care during chronic and life-threatening illnesses. The interim committee was required to meet at least six times during the 2009 interim.

## Committee Activities

The Interim Committee to Study Hospice and Palliative Care met six times during the 2009 interim. The meetings focused on a variety of topics including an overview of hospice and palliative care, barriers to accessing and utilizing hospice and palliative care, advanced care directive forms, and issues concerning coroners and pronouncement of death.

## Overview of Hospice and Palliative Care

The committee heard from various providers and stakeholders who described services included in hospice and palliative care. Stakeholders and providers who provided information to the committee included the Colorado Center for Hospice and Palliative Care, the Department of Public Health and Environment (DPHE), the Advanced Directive Consortium, the Center for Improving Value in Health Care (CIVHC), the Denver Hospice, chaplains, ethicists, coroners, physicians and nurses who provide palliative care, and other advocates in the community.

***Hospice care.*** Hospice care is designed to treat pain and the symptoms of end-stage illness and provide care for individuals and families. Hospice care neither hastens or postpones the death of an individual, but rather focuses on quality of life for the individual and family members at the end of life. Hospice care services include developing a plan of care for individuals who are exhibiting end-stage illness, administering pain medication, and addressing the psychological and spiritual concerns of patients and family members regarding issues surrounding death. Hospice care can be provided in a home, a hospital, an assisted living facility, a nursing home, or a hospice residential unit. Hospice services can be paid by Medicare, Medicaid, private insurance, or a combination. In order to be eligible for hospice coverage under Medicare or Medicaid, a physician must verify that an individual has a six-month life expectancy prognosis. Data was presented to the committee which demonstrated that the average length of stay in a hospice in Colorado is 20 days, with the national average being 24 days.

Providers indicated that the longer an individual requires hospice services, the better the provider is able to offset the costs of individuals who have no access to health insurance or public health programs. There was discussion among the committee that if the eligibility period for Medicaid hospice coverage was increased from six months to nine months, the length of stay in hospice care may increase, thus increasing reimbursement to hospices. In addition, providers indicated that increasing the eligibility period for hospice would save money by reducing hospitalizations, unnecessary prescriptions, and emergency room visits. As a result of this discussion, the committee recommends Bill C, which, pending federal approval, increases the eligibility period for the life expectancy prognosis from six to nine months for purposes of Medicaid.

***Palliative care.*** Palliative care was described to the committee as the relief of physical and personal distress for individuals with a terminal illness or a chronic disease. Palliative care consultants aim to understand a patient's values and goals, manage their symptoms of illness or chronic disease, and coordinate care. Advocates indicated that palliative care is often administered through multi-disciplinary teams which include physicians, social workers, nurses, and spiritual personnel. Palliative care is an integrated care model that focuses on comfort and qualify of life versus a traditional care model that focuses on curative measures with a short period of time focused on death. Palliative care is offered by Kaiser Permanente, University Hospital, Children's Hospital, Memorial Hospital, the Exempla, HealthOne, and Centura hospital systems, and the Veterans Administration.

## Barriers to Accessing and Utilizing Hospice and Palliative Care

The committee discussed several barriers to the access and use of hospice and palliative care. Specifically the committee discussed issues related to administrative savings of hospice and palliative care services and patient and family members' attitudes toward death.

***Administrative savings.*** Committee members heard testimony from several providers on ways in which the committee could implement administrative changes that would increase cost savings. Some of these changes include simplifying the billing process for reimbursement or allowing Medicaid to reimburse hospices directly for providing residential level of care for room and board in a hospice inpatient facility. As a result of these discussions, the committee recommends Bill E, which requires the Department of Health Care Policy and Financing, pending federal approval, to pay a nursing facility directly for inpatient services provided to a Medicaid recipient rather than paying the hospice care provider who then pays the nursing facility, thus reducing administrative burden and increasing administrative efficiencies.

***Fear of death.*** One barrier to access discussed by the committee was an individual's fear to receive hospice services. Many advocates spoke to the fear that entering a hospice equates to a lack of hope or the notion that the person is "about to die." Advocates suggested that in many cases, individuals who received palliative care were more comfortable using palliative services because the focus is on quality of life, rather than the end of life. Many advocates spoke to the need to educate the public regarding the services provided to hospice and palliative care clients. Advocates also discussed educating physicians about how to approach the topic of advanced care planning. Providers noted that many physicians come from a "curative care" school of thought, meaning some find it difficult to discuss options outside of curative care.

## End of Life Decisions

**Advanced care directives**. The committee heard from several advocates regarding the definition and the appropriate use of the various advance directive forms. Advanced care directives forms are meant to allow "advance care planning" where individuals make decisions concerning medical decisions ahead of potential medical difficulties. Advanced care directives are not intended just for the terminally ill or those with chronic disease, but for any person who wants to see his or her wishes respected in times when he or she may be unable to make medical decisions. The committee heard about several different advance care directive forms. Each form has different requirements, such as a signature by a physician or advanced practice nurse, to be considered legal or valid by an emergency medical professional.

Advance care planning assumes that a competent adult or adult with decision-making capacity is making decisions. Some of the advance care decisions represented on the different forms include the right to refuse any treatment at any time for any reason, the right to determine what types of treatment may be used when an individual is rendered incompetent, the right to determine when a person wants to be resuscitated, and the right to decide what happens to a person's body in case of death. Advanced care directive forms include:

- CPR directives;
- living wills;
- a Medical durable power of attorney;
- the Five Wishes form;
- the Medical Orders for Scope of Treatment (MOST); and
- the Physician Orders for Life Sustaining Treatment (POLST), the Medical Orders for Life Sustaining Treatment (MOLST), and the Physician Orders for Scope of Treatment (POST).

***Differences in the various forms.*** Various stakeholders, including members from the CDPHE, the Colorado Advance Directive Consortium, and the Palliative Care Subcommittee of the Center for Improving Value in Health Care, testified to the committee regarding the pros and cons of each form. During committee, there was considerable discussion regarding which form was the most comprehensive, effective, and reflective of an individual's wishes, and the easiest to use. Committee members considered legislation that would have established the MOST form in Colorado law, however the legislation was withdrawn from consideration. As a result of these discussions, the committee recommends Bill B, which establishes a central on-line registry of advanced care directives, and Bill D, which updates the Colorado Medical Treatment Act.

**Declaring patients terminally ill.** During the 2008 legislative session, House Bill 08-1061 authorized advanced practice nurses (APNs) to sign certain documents, like disabled parking permits. Specifically, the bill authorized APNs to certify a terminal illness of a patient. According to testimony provided during the interim committee, APNs consider determining or certifying the terminal illness of a patient outside the scope of their practice. As a result of this discussion, Bill A, which reverts the statutory language changed by the passage of House Bill 08-1061 back to its original language excluding APNs' ability to certify a terminal illness, is recommended. Under the legislation proposed, solely physicians would have the authority to declare or certify a terminally illness.

## Coroners and Hospice Interactions

The committee heard presentations from the Colorado Coroner's Association and various hospice providers regarding issues such as pronouncement of death, signing death certificates, the process in which the coroner is informed about a deceased hospice patient, and other issues. Hospice care providers testified that each coroner has a different procedure regarding pronouncement of death. Some counties require that a coroner investigate all deaths in a hospice, and some do not. Some coroners remove the deceased patient's medication or driver's license from the hospice setting, whereas others do not. Some hospices pre-register their patients with the coroner's office. Committee members discussed whether legislation was necessary to require that all coroners have the same processes in place regarding the legal pronouncement of death. Individuals testified that a "one size fits all approach" would not be effective in every county. Coroners and members of the hospice community agreed to work outside of the legislative process to address some of the issues surrounding pronouncement of death, who takes possession of medication, when to call the police, pre-registration, and other procedures.

## Committee Recommendations

As a result of committee deliberations, the Interim Committee to Study Hospice and Palliative Care recommends five bills for consideration during the 2010 legislative session.

**Bill A — Eliminating the Ability of Advanced Practice Nurses to Declare Patients Terminally Ill.** Bill A eliminates the ability of advanced practice nurses (APNs) to declare a patient terminally ill for the purposes of triggering end-of-life decisions and leaves such ability to the sole discretion of a physician. During the 2008 legislative session, House Bill 08-1061 authorized APNs to sign certain documents, like disabled parking permits. The bill also authorized APNs to certify a terminal illness of a patient. According to testimony provided in committee, APNs consider determining or certifying the terminal illness of a patient outside of the scope of their practice. Therefore Bill A reverts statutory language back to its original language prior to the passage of House Bill 08-1061 with regard to APNs' ability to certify a terminal illness.

**Bill B — Establishing A Central On-Line Registry of Medical Orders for Scope of Treatment Forms.** Bill B requires the Department of Public Health and Environment to create and maintain an on-line registry of medical orders for scope of treatment (MOST) forms. Bill B allows individuals to electronically submit completed MOST forms to the registry and stipulates that physicians may access the forms with his or her national provider identifier number. Further, Bill B requires the department to implement appropriate data security measures to ensure confidentiality of the contents.

**Bill C — Increasing The Life Expectancy Prognosis For Persons Receiving Hospice Care Through Medicaid.** Currently, Colorado law requires a certified medical prognosis of life expectancy of six months or less for a patient to be eligible for hospice care under Medicaid. Bill C increases the life expectancy prognosis to nine months if the Department of Health Care Policy and Financing receives federal authorization to extend the time period.

**Bill D — Colorado Medical Treatment Act Update.** Bill D repeals and reenacts the Colorado Medical Treatment Decision Act, which outlines patient rights regarding medical treatment decisions. The act defines certain terms such as "artificial nourishment and hydration," "lacking decisional capacity," and "persistent vegetative state." Bill D affirms a patient's right to accept or reject medical or surgical treatment, and clarifies procedures by which an adult with decisional capacity may make decisions regarding one's health in advance of medical need.

**Bill E — Medicaid Hospice Room and Board Changes.** Bill E requires the Department of Health Care Policy and Financing to pay a nursing facility directly for inpatient services provided to a Medicaid recipient who is receiving hospice care, rather than paying the hospice care provider who then pays the nursing facility. Bill E stipulates that the change in reimbursement must be approved by the federal Centers for Medicare and Medicaid Services.

## Committee Charge

Pursuant to House Joint Resolution 09-1017, the Interim Committee to Study Hospice and Palliative Care was comprised of five members of the House of Representatives and five members of the Senate, and was required to meet six times during the 2009 interim.

The committee was charged with considering the barriers and disincentives that prohibit or prevent patients from receiving hospice and palliative care during chronic and life threatening illnesses. The committee was permitted to consider the following issues:

- the barriers to accessing and utilizing hospice and palliative care in urban and rural areas of the state;
- the economics and cost savings of hospice and palliative care, including the cost savings of Medicaid residential level of hospice care in a hospice facility;
- coverage of hospice and palliative care under private health insurance and Medicaid plans, including the Colorado Indigent Care Program;
- oversight of the quality of hospice and palliative care programs in the state;
- factors contributing to ethical dilemmas at the end of life, and methods to reduce those factors, including clarifying laws and regulations regarding advance directives; and
- factors limiting the efficacy of the provision of hospice and palliative care, including laws and regulations pertaining to the legal pronouncement of death.

## Committee Activities

The committee met six times during the 2009 interim. At these hearings, the committee received briefings on a broad range of topics concerning end-of-life issues. The committee heard testimony from hospice care providers, advocacy organizations, representatives involved in the delivery of palliative care, and state department representatives.

### Hospice Care

The committee heard several presentations regarding hospice care in Colorado. Specifically, the Colorado Center for Hospice and Palliative Care, a advocacy organization for hospice care centers in Colorado, rural and urban hospice providers, and other stakeholders provided testimony to the committee regarding their experiences concerning hospice care.

The Colorado Center for Hospice and Palliative Care provided an overview of hospice care to the committee. A representative from the center informed the committee that hospice is designed to treat pain and the symptoms of end-stage illness and provide care for individuals and their families. Hospice care neither hastens or postpones death of an individual, but rather focuses on the quality of life for an individual and family members at the end of life. Hospice care services include developing a plan of care for individuals who are exhibiting end-stage illness, administering pain medication, and addressing the psychological and spiritual concerns of patients and family members regarding issues surrounding death. Committee members learned that hospice care can be provided in a home, a hospital, an assisted living facility, a nursing home, and a hospice residential unit.

Committee members heard testimony from several providers regarding how individuals die in America. The committee was presented information from the Journal of the American Medical Association that indicated that approximately 38 percent of Americans spend the last 10 days of their life in an intensive care unit in a hospital. The journal also found that a majority of adults prefer to be cared for in their homes, yet nearly 75 percent of Americans die in a hospital or a nursing home.

Committee members heard testimony from both rural and urban hospice care providers throughout the state. The providers described payment methods for hospice which include Medicare, Medicaid, private insurance, or a combination. A representative from the Centers for Medicare and Medicaid informed the committee that in order to be eligible for coverage under Medicare or Medicaid, a physician must verify that an individual has a six-month life expectancy prognosis. The Colorado Center for Hospice and Palliative Care presented data to the committee that indicated that the average length of stay in a hospice in Colorado is 20 days, with the national average being 24 days.

Providers indicated that if the eligibility period for coverage under Medicare or Medicaid was increased from six months to nine months, the length of stay in a hospice may increase. Increasing the length of stay in a hospice, providers' testified, would help the financial solvency of hospices as the longer an individual requires hospice services, the better the provider is able to offset the costs of individuals who have no access to health insurance or public health programs. In addition, providers indicated that increasing the eligibility period for hospice would save costs to the entire health care system by reducing unnecessary hospitalizations, needless prescriptions, and costly emergency room visits.

The Department of Public Health and Environment (CDPHE) provided testimony regarding the process in which hospices are licensed, the oversight the department provides in monitoring complaints against hospices, and the regulations that hospices must comply with in order to maintain their license. The department stated that Colorado has 50 licensed hospices with 104 beds. Initial licensing of a hospice requires an on-site survey by the department. The department indicated that due to funding issues, the department is not currently conducting initial on-site surveys. The committee discussed increasing hospice license fees which would allow the department to resume initial on-site surveys and increase oversight abilities of the department.

***Committee recommendation.*** As a result of the committee's discussions regarding hospices and reimbursement for services, the committee recommends Bill C, which increases the eligibility period of life expectancy prognosis from six to nine months. The bill requires the Department of Health Care Policy and Financing (DHCPF) to receive approval from the federal Centers for Medicaid and Medicare to extend the period of time.

## Palliative Care

The committee heard several presentations regarding palliative care in Colorado. The committee heard from palliative care providers including physicians and advanced practice nurses who provide palliative care to adults and children in their homes and hospital settings.

Palliative care is designed to relieve the physical and personal distress for individuals with a terminal illness or a chronic disease. Palliative care consultants aim to understand a patient's values and goals, manage their symptoms of illness or chronic disease, and coordinate care. Advocates indicated that palliative care is typically administered through multi-disciplinary teams which include physicians, social workers, nurses, and spiritual personnel.

Palliative care is delivered through an integrated care model that focuses on comfort and qualify of life. Committee members heard testimony on the differences between a traditional care model that focuses on curative measures with a short period of time focused on death versus the integrated care model that focuses on comfort and quality of life. Providers of palliative care indicated that while the integrated care model is effective and efficient, these services are not reimbursed under Medicaid or Medicare program.

Representatives of palliative care organizations indicated that there are approximately 59 certified palliative care providers in Colorado including 7 in rural areas of the state. Palliative care can be provided in a hospital or a home setting. Palliative care is offered by Kaiser Permanente, University Hospital, Children's Hospital, Memorial Hospital, the Exempla, HealthOne, Centura hospital systems, and the Veterans Administration.

A representative from the Children's Hospital described the Butterfly Program, which provides pediatric palliative care to children. The representative stated that the model for pediatric palliative care is quite different than that of an adult model as children may still receive curative care and that the eligibility period of life expectancy is 12 months versus 6 months. Members discussed the Butterfly Program which is considered a national model for pediatric palliative care.

No draft legislation was proposed by the committee as a result of the discussion of palliative care.

## Barriers to Accessing and Utilizing Hospice and Palliative Care Services

The committee discussed several barriers to access and use of hospice and palliative care services in Colorado. Specifically, the committee discussed issues related to the reimbursement of hospice services and patient attitudes towards death.

***Reimbursement.*** A representative from a hospice in Morgan County, Colorado, indicated that the county's hospice is affected by economies of scale and that a drop in the number of patients can have a substantial impact on the finances of the organization. Under Medicaid and Medicare, hospice services are reimbursed at a per diem rate. The committee was informed that under Medicaid and Medicare, there are four levels of reimbursement which correspond to levels of treatment. For example, the highest level of reimbursement is for general inpatient care. Hospice providers indicated that the reimbursement structure favors hospice care services that are provided in the home rather than a hospital. Providers indicated that the longer an individual requires hospice services, the better the provider is able to spread his or her costs.

Providers testified about the administration of hospice care. It was described to the committee that payment for services for Medicaid receiptiants in a nursing facility first goes to a hospice. The hospice is then responsible for paying the nursing facility. Providers indicated that paying the nursing facility directly rather than have payment pass through a hospice and then onto the nursing facility could reduce administrative burden and make the system more effective.

***Fear of death.*** One barrier to access discussed by the committee are individuals' general fear of death. Many advocates spoke to the fear and anxiety many individuals express about death. Advocates indicated that individuals equate receiving hospice services to a lack of hope or the notion that the person is "about to die." Advocates suggested that in many cases, individuals who received palliative care were more comfortable using palliative services rather than hospice services because palliative care services do not imply that death is imminent. Many advocates

spoke to the need for educating the public regarding the services provided to hospice and palliative care clients. Advocates also spoke to educating physicians about how to approach the topic of advanced care planning. Presenters noted that many physicians, because they come from a "curative care" school of thought, find it difficult to discuss death or options outside of curative care.

***Committee recommendation.*** As a result of the discussions regarding reimbursement methods, the committee recommends Bill E which requires the DHCPF, pending federal approval, to pay a nursing facility directly for inpatient services provided to a Medicaid recipient rather than paying the hospice care provider who then pays the nursing facility.

## End of Life Decisions

The committee heard from several advocates regarding the definition and the appropriate use of the various advance directive forms. Advanced care directive forms are designed to allow advance care planning so that individuals can make medical decisions ahead of potential medical difficulties. Advanced care directives are not intended just for the terminally ill or those with chronic disease, but for any person who wants to see his or her wishes respected in times when he or she may be unable to make medical decisions. Advance care planning assumes, and at times requires, that a competent adult is making decisions regarding end-of-life issues. The committee heard testimony regarding the different uses of the advance care directive forms. Each form has different requirements, such as a signature by a physician or advanced practice nurse, and has a different goal, such as indicating an individual's desire for life sustaining treatment or an individual's directives concerning cremation or burial. A brief description of each of the advanced care directive forms is provided below.

- ***CPR directive***. A CPR directive is a statement of refusal of cardiopulmonary resuscitation. In order to be valid, the directive must be signed by a physician and the individual requesting the directive. An individual must be of sound mind and be at least 18 years old to create a CPR directive. Presenters indicated that one of the difficulties of using a CPR directive is that unless it is presented to emergency medical technicians, it may not be honored.

- ***Living will.*** A living will expresses the intentions of an individual concerning the individual's wishes pertaining to withdrawal of life-sustaining treatment. A living will can authorize the removal of artificial nutrition or specify other intentions with regard to remaining in a persistent vegetative state. In order to authenticate a living will, an individual must be of sound mind and be at least 18 years of age, and the form must be witnessed by two individuals. A living will cannot be executed or overridden by a surrogate. Presenters discussed that one of the difficulties in using the document is that it is often not available when medical decisions take place, or that a family member resists its implementation.

- ***Medical Durable Power of Attorney (MDPA*).** A MDPA is a designation of a surrogate decision-maker. In order to authenticate a MDPA, an individual must be at least 18 years of age and of sound mind and the form must be signed by two witnesses. Presenters indicated that the MDPA document is useful because it is easily accessible and cannot be overridden by a living will or a CPR directive.

- ***Five Wishes.*** The Five Wishes form incorporates an individual's decisions regarding health, such as whether the individual wants life sustaining treatments, and personal decisions, such as his or her preferred place of death. The document has legal standing in Colorado and revokes all previously executed health care advance directives once signed. One aspect the Five Wishes form does not provide is authoritative instructions on the administration of CPR. The document must be signed by a person who is of sound mind and who is at least 18 years of age, and the form must be signed by two witnesses.

- ***Other forms.*** The Medical Orders for Scope of Treatment (MOST) form provides information on key areas of medical treatment, such as orders for administration of CPR, whether an individuals wants life sustaining treatment, whether antibiotics should be administered, and other health-care related decisions. It also incorporates personal decisions such as preferred place of death. In order to validate the form, it must be signed by an individual who is 18 years of age with decision-making capacity at the time of signature. The form must also be signed by a physician or an advanced practice nurse. The committee heard testimony on several other forms including the Physician Orders for Life Sustaining Treatment (POLST), the Medical Orders for Life Sustaining Treatment (MOLST), and the Physician Orders for Scope of Treatment (POST).

***Differences in the various forms.*** Various stakeholders, including members from the CDPHE, the Colorado Advance Directive Consortium, and the Palliative Care Subcommittee of the Center for Improving Value in Health Care, provided testimony to the committee regarding the pros and cons of each form. During committee, there was considerable discussion regarding which form was the most comprehensive, most effective, most reflective of an individual's wishes, and the easiest to use. Committee members considered legislation that would have recognized the MOST form into Colorado law, however the bill was withdrawn from consideration.

***Ethical dilemmas.*** Members of the committee heard testimony from various witnesses regarding ethical dilemmas which may occur at the end of one's life. Witnesses described some of the ethical dilemmas that individuals and family members face at the end of life, specifically when individuals have terminal illness. Witnesses spoke to decisions family members make when individuals have not provided an advanced care directive. Members of the committee also heard from spiritual personnel regarding their interactions with individuals who are terminal, as well as family members.

***Declaring patients terminally ill.*** During the 2008 legislative session, House Bill 08-1061 authorized advanced practice nurses (APNs) to sign certain documents, like disabled parking permits. Additionally, the bill authorized APNs to certify a terminal illness of a patient. According to testimony provided during the interim committee, APNs consider determining or certifying the terminal illness of a patient outside the scope of their practice. APNs and representatives from the Colorado Medical Society agreed that legislation was necessary to revert the statutory language changed by the passage of House Bill 08-1061.

***Committee recommendations***. As a result of committee discussions regarding end of life decisions, the committee recommends three bills. Bill A reverts the statutory language changed by the passage of House Bill 08-1061 back to its original language which excludes APNs' from certifying a terminal illness. Under the legislation, solely physicians would have the authority to declare or certify a terminally illness. Bill B creates an on-line registry of advanced care directives with restrictions on who may access the database, specifically physicians. Bill D, which updates

the Colorado Medical Treatment Act, is also recommended by the committee. The Colorado Medical Treatment Act outlines patient rights regarding medical treatment decisions. Bill D defines certain terms such as "artificial nourishment and hydration," "lacking decisional capacity," and "persistent vegetative state." Bill D also affirms a patient's right to accept or reject medical or surgical treatment, and clarifies procedures by which an adult with decisional capacity may make decisions regarding one's health in advance of medical need.

## Coroners and Hospice Interactions

The committee heard from the Colorado Coroner's Association and various hospice providers regarding issues such as pronouncement of death, signature of death certificates, the process in which the coroner is informed about a deceased hospice patient, and other issues. Presenters indicated that coroners determine cause of death, sign the death certificate, and designate a representative to pick up the body from a hospice or a person's home.

Hospice care providers testified that each coroner has a different procedure regarding pronouncement of death. Some counties require that a coroner investigate all deaths that occur in a hospice, and some do not. Some coroners take the deceased patient's medication or driver's license, whereas others do not. Some hospices are required to pre-register their patients with the coroner's office. Committee members discussed whether legislation was necessary to require that all coroners have the same process in place regarding the legal pronouncement of death. The committee heard testimony that a "one size fits all approach" would not be the most effective as each county in Colorado is different. Coroners and members of the hospice community agreed to work outside of the legislative process to address some of the issues surrounding pronouncement of death.

## Summary of Recommendations

As a result of committee deliberation, the committee recommends five bills for consideration during the 2010 legislative session.

### Bill A — Eliminating the Ability of Advanced Practice Nurses to Declare Patients Terminally Ill

Bill A eliminates the ability of advanced practice nurses (APNs) to declare a patient terminally ill for the purposes of triggering end-of-life decisions and leaves such ability to the sole discretion of a physician. During the 2008 legislative session, House Bill 08-1061 authorized APNs to sign certain documents, like disabled parking permits. The bill also authorized APNs to certify a terminal illness of a patient. In testimony provided in committee, APNs consider determining or certifying death or terminal illness of a patient outside of the scope of their practice. Therefore, Bill A reverts statutory language back to the language that existed prior to the passage of House Bill 08-1061 with regard to APN's ability to certify a terminal illness.

### Bill B — Establishing A Central On-Line Registry of Medical Orders for Scope of Treatment Forms

Bill B requires the Department of Public Health and Environment to create and maintain an on-line registry of medical orders for scope of treatment (MOST) forms. The MOST form is an advance care directive that indicates an individual's desire with regard to various end of life decisions, such as whether an individual wants life-sustaining treatment or place of burial preference. The department must make downloadable MOST forms available to the public on its website, and allow individuals to electronically submit completed MOST forms to the registry. The bill stipulates that physicians may access the registry with his or her national provider identifier number. Further, Bill B requires the department to implement appropriate data security measures to ensure confidentiality of the contents. The bill creates the Medical Funds On-line Registry Cash Fund, and permits the department to accept gifts, grants, and donations to implement the registry.

### Bill C — Increasing The Life Expectancy Prognosis For Persons Receiving Hospice Care Through Medicaid

Currently, Colorado law requires a certified medical prognosis of life expectancy of six months or less for a patient to be eligible for hospice care under Medicaid. Bill C increases the life expectancy prognosis to nine months if the Department of Health Care Policy and Financing receives federal authorization to extend the period of time. The bill also instructs the department to inform the Revisor of Statutes if and when the required federal authorization is received.

### Bill D — Colorado Medical Treatment Act Update

Bill D repeals and reenacts the Colorado Medical Treatment Decision Act which provides a foundation of patient rights and definitions regarding medical treatment decisions. The act defines certain terms such as "artificial nourishment and hydration," "lacking decisional capacity,"

and "persistent vegetative state." Bill D affirms the traditional right to accept or reject medical or surgical treatment, and clarifies the procedures by which an adult with decisional capacity may declare his or her preferred medical treatment in the event he or she is in a terminal condition, persistent vegetative state, or otherwise lacks decisional capacity to accept or reject medical treatment. Bill D removes the legal form in statute regarding what the declaration regarding medical treatment must take. It also removes penalties in statute for destroying, falsifying, or forging a declaration or withholding information about a declaration.

## Bill E — Medicaid Hospice Room and Board Changes

Bill E requires the Department of Health Care Policy and Financing to pay a nursing facility directly for inpatient hospice services provided to a Medicaid recipient rather than paying the hospice care provider who then pays the nursing facility. Bill E stipulates that the change in reimbursement must be approved by the federal Centers for Medicare and Medicaid, and authorizes the department to accept gifts, grants, and donations to cover any administrative costs incurred when seeking federal approval.

## Resource Materials

Meeting summaries are prepared for each meeting of the committee and contain all handouts provided to the committee. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver (303-866-4900). The listing below contains the dates of committee meetings and the topics discussed at those meetings. Meeting summaries are also available on our website at:

***http://www.colorado.gov/lcs/HospiceandPalliativeCare***

### Meeting Date and Topics Discussed

July 8, 2009

- Overview of hospice and palliative care
- Hospice utilization in rural and urban areas
- Reimbursement of hospice and palliative care services
- Barriers to utilization of hospice care

July 9, 2009

- Challenges for urban hospices
- National overview of palliative care
- Medicare coverage of hospice care
- Overview of hospice licensing and reporting
- Pediatric hospice and palliative care
- End-of-life decision making

July 27, 2009

- CPR directives and Medical Orders for Scope of Treatment forms
- Medicaid coverage of hospice and palliative care
- Insurance coverage of palliative care
- Issues related to the legal pronouncement of death
- Ethical dilemmas related to end-of-life care
- In-home care and hospice care

September 1, 2009

- Advance care planning
- End-of-life decision making
- Update on the Center for Improving Value in Health Care
- Long-term health care facilities
- Spiritual and ethical concerns with end-of-life care
- National health care reform
- Veterans hospice and palliative care

September 24, 2009

- Hospital-provided palliative care
- Advance directives
- Summary of committee discussion and findings
- Update on federal hospice and palliative care issues
- Discussion of potential draft legislation

October 20, 2009

- Discussion and approval of proposed committee legislation

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

**BILL A**

LLS NO. 10-0247.01 Jane Ritter **HOUSE BILL**

**HOUSE SPONSORSHIP**

**Balmer and Riesberg,**

**SENATE SPONSORSHIP**

**Williams,** Newell

**House Committees** **Senate Committees**

## A BILL FOR AN ACT

**CONCERNING ELIMINATING THE ABILITY OF ADVANCED PRACTICE NURSES TO DECLARE PATIENTS TERMINALLY ILL.**

### Bill Summary

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

**Hospice and Palliative Care in Colorado.** The bill eliminates the ability of advanced practice nurses to declare a patient terminally ill for purposes of triggering end-of-life decisions and leaves such ability to the sole discretion of a physician.

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

**SECTION 1.** 15-18-104 (2) and (3), Colorado Revised Statutes, are amended to read:

**15-18-104. Declaration as to medical treatment.** (2) In the case of a declaration of a qualified patient known to the attending physician ~~or advanced practice nurse~~ to be pregnant, a medical evaluation shall be made as to whether the fetus is viable and could with a reasonable degree of medical certainty develop to live birth with continued application of life-sustaining procedures. If such is the case, the declaration shall be given no force or effect.

(3) A declaration executed before two witnesses by any competent adult shall be legally effective for the purposes of this article and may, but need not, be in the following form:

**DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT**

I, (name of declarant), being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

1. If at any time my attending physician ~~or advanced practice nurse~~ and one other qualified physician ~~or advanced practice nurse~~ certify in writing that:

a. I have an injury, disease, or illness which is not curable or reversible and which, in their judgment, is a terminal condition, and

b. For a period of seven consecutive days or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person, then

I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not

include any medical procedure or intervention for nourishment considered necessary by the attending physician or advanced practice nurse to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.

2. In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken:

(initials of declarant) a. Artificial nourishment shall not be continued when it is the only procedure being provided; or

(initials of declarant) b. Artificial nourishment shall be continued for _____ days when it is the only procedure being provided; or

(initials of declarant) c. Artificial nourishment shall be continued when it is the only procedure being provided.

3. I execute this declaration, as my free and voluntary act, this _____ day of _____, 20___.

By_____

Declarant

The foregoing instrument was signed and declared by _____ to be his OR HER declaration, in the presence of us, who, in his OR HER presence, in the presence of each other, and at his OR HER request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence.

Dated at _____, Colorado, this _____ day of _____, 20___.

_____

Name and Address

_____

Name and Address

STATE OF COLORADO )

) ss.

County of _____)

SUBSCRIBED and sworn to before me by _____, the declarant, and _____ and _____, witnesses, as the voluntary act and deed of the declarant this _____ day of _____, 20___.

My commission expires:

_____

Notary Public

**SECTION 2. Act subject to petition - effective date.** This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall not take effect unless approved by the people at the general election to be held in November 2010 and shall take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

**BILL B**

LLS NO. 10-0248.01 Richard Sweetman **HOUSE BILL**

**HOUSE SPONSORSHIP**

**Tyler,** Riesberg, Soper

**SENATE SPONSORSHIP**

**Tochtrop,** Williams

**House Committees** **Senate Committees**

**A BILL FOR AN ACT**

**CONCERNING A CENTRAL ON-LINE REGISTRY OF MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS.**

**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

**Hospice and Palliative Care in Colorado.** This bill requires the department of public health and environment (department) to create and maintain an on-line registry of medical orders for scope of treatment forms (registry). The bill also creates the medical forms on-line registry cash fund (fund) and authorizes the department to solicit and accept gifts, grants, and donations to the fund to create and maintain the registry.

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

**SECTION 1.** Part 1 of article 1.5 of title 25, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

**25-1.5-110. Central registry for medical orders for scope of treatment forms - cash fund.** (1) ON AND AFTER JULY 1, 2010, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT SHALL CREATE AND MAINTAIN ON ITS PUBLIC WEB SITE A CENTRAL REGISTRY FOR MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS AS DESCRIBED IN THIS SECTION.

(2) THE CENTRAL REGISTRY CREATED AND MAINTAINED PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL:

(a) MAKE AVAILABLE TO MEMBERS OF THE PUBLIC MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS AS DOWNLOADABLE DOCUMENTS FROM THE REGISTRY;

(b) ALLOW MEMBERS OF THE PUBLIC TO ELECTRONICALLY SUBMIT COMPLETED MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS TO THE REGISTRY;

(c) STORE COMPLETED MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS THAT HAVE BEEN SUBMITTED TO THE REGISTRY BY MEMBERS OF THE PUBLIC;

(d) IMPLEMENT APPROPRIATE DATA SECURITY TECHNOLOGY TO ENSURE THE CONFIDENTIALITY OF THE CONTENTS OF COMPLETED MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS THAT HAVE BEEN SUBMITTED TO THE REGISTRY BY MEMBERS OF THE PUBLIC; AND

(e) ALLOW A PHYSICIAN TO USE HIS OR HER NATIONAL PROVIDER IDENTIFIER NUMBER, WHICH NUMBER HAS BEEN ISSUED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES WITHIN THE UNITED STATES

DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO ACCESS COMPLETED MEDICAL ORDERS FOR SCOPE OF TREATMENT FORMS THAT HAVE BEEN SUBMITTED TO THE REGISTRY BY MEMBERS OF THE PUBLIC.

(3) IN ADDITION TO ANY FUNDS APPROPRIATED FOR THE IMPLEMENTATION OF THIS SECTION, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT IS AUTHORIZED TO SOLICIT AND ACCEPT GIFTS, GRANTS, OR DONATIONS OF ANY KIND FROM ANY PRIVATE SOURCE OR FROM ANY GOVERNMENTAL UNIT TO CARRY OUT THE PURPOSES OF THIS SECTION SUBJECT TO THE CONDITIONS UPON WHICH THE GIFTS, GRANTS, OR DONATIONS ARE MADE; EXCEPT THAT NO GIFT, GRANT, OR DONATION SHALL BE ACCEPTED IF THE CONDITIONS ATTACHED THERETO REQUIRE THE USE OR EXPENDITURE THEREOF IN A MANNER CONTRARY TO LAW OR REQUIRE EXPENDITURES FROM THE GENERAL FUND UNLESS SUCH EXPENDITURES ARE APPROVED BY THE GENERAL ASSEMBLY. ALL SUCH GIFTS, GRANTS, OR DONATIONS SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE CASH FUND CREATED IN SUBSECTION (4) OF THIS SECTION.

(4) (a) THERE IS HEREBY CREATED IN THE STATE TREASURY THE MEDICAL FORMS ON-LINE REGISTRY CASH FUND. THE CASH FUND SHALL CONSIST OF:

(I) SUCH MONEYS AS MAY BE APPROPRIATED TO THE CASH FUND BY THE GENERAL ASSEMBLY;

(II) ANY GIFTS, GRANTS, OR DONATIONS RECEIVED BY THE DEPARTMENT FOR THE CASH FUND PURSUANT TO SUBSECTION (3) OF THIS SECTION; AND

(III) ANY OTHER MONEYS DIRECTED TO THE CASH FUND BY THE DEPARTMENT.

(b) THE MONEYS IN THE CASH FUND SHALL BE SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE DIRECT AND INDIRECT COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THE

REGISTRY PURSUANT TO THE PROVISIONS OF THIS SECTION.

(c) ANY MONEYS IN THE CASH FUND NOT EXPENDED FOR THE PURPOSE OF THIS SECTION MAY BE INVESTED BY THE STATE TREASURER AS PROVIDED BY LAW. ALL INTEREST AND INCOME DERIVED FROM THE INVESTMENT AND DEPOSIT OF MONEYS IN THE CASH FUND SHALL BE CREDITED TO THE CASH FUND. ANY UNEXPENDED AND UNENCUMBERED MONEYS REMAINING IN THE CASH FUND AT THE END OF A FISCAL YEAR SHALL REMAIN IN THE CASH FUND AND SHALL NOT BE CREDITED OR TRANSFERRED TO THE GENERAL FUND OR ANOTHER FUND.

**SECTION 2. Act subject to petition - effective date.** This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall not take effect unless approved by the people at the general election to be held in November 2010 and shall take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

**BILL C**

LLS NO. 10-0249.01 Brita Darling **HOUSE BILL**

**HOUSE SPONSORSHIP**

**Roberts and Tyler,** Soper

**SENATE SPONSORSHIP**

**Williams,** Newell

**House Committees** **Senate Committees**

## A BILL FOR AN ACT

**CONCERNING THE REQUIREMENT FOR A CERTAIN LIFE EXPECTANCY PROGNOSIS FOR PERSONS RECEIVING HOSPICE CARE THROUGH MEDICAID.**

### Bill Summary

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

**Hospice and Palliative Care in Colorado.** Currently, Colorado law requires a certified medical prognosis of life expectancy of 6 months or less for a patient for hospice care to be provided under medicaid. This bill increases the life expectancy prognosis to 9 months if the department of health care policy and financing (department) receives the necessary federal authorization. The executive director of the department shall

notify the revisor of statutes within 60 days after receipt of federal authorization.

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

**SECTION 1.** The introductory portion to 25.5-5-304 (1) and 25.5-5-304 (1) (a), Colorado Revised Statutes, are amended, and the said 25.5-5-304 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

**25.5-5-304. Hospice care - repeal.** (1) The medical assistance program in this state shall include hospice care. Except as otherwise provided in subsection (2) of this section, hospice care shall be provided for a period of up to two hundred ten days in accordance with rules adopted by the state board, which rules shall comply with ~~section 1905 of the social security act,~~ 42 U.S.C. sec. 1396d, and shall include at least the following requirements:

(a) That a person shall obtain a certified medical prognosis indicating a life expectancy of ~~six~~ NINE months or less, which certification shall comply with rules adopted by the state board;

(3) (a) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION, UNTIL THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION TO INCREASE THE CERTIFIED MEDICAL PROGNOSIS FOR LIFE EXPECTANCY TO NINE MONTHS OR LESS, A CERTIFIED MEDICAL PROGNOSIS INDICATING A LIFE EXPECTANCY OF SIX MONTHS OR LESS SHALL BE REQUIRED.

(b) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO INCREASE THE CERTIFIED MEDICAL PROGNOSIS FOR LIFE EXPECTANCY TO NINE MONTHS OR LESS, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF STATUTES INFORMING

HIM OR HER OF THE AUTHORIZATION. THIS SUBSECTION (3) IS REPEALED, EFFECTIVE THE JULY 1 FOLLOWING THE RECEIPT OF THE NOTICE BY THE REVISOR OF STATUTES.

**SECTION 2. Act subject to petition - effective date.** This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall not take effect unless approved by the people at the general election to be held in November 2010 and shall take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

**BILL D**

LLS NO. 10-0250.01 Jane Ritter **HOUSE BILL**

**HOUSE SPONSORSHIP**

**Roberts,** Riesberg, Soper, Tyler

**SENATE SPONSORSHIP**

**Newell,** Tochtrop, Williams

**House Committees** **Senate Committees**

**A BILL FOR AN ACT**

**CONCERNING UPDATES TO THE "COLORADO MEDICAL TREATMENT DECISION ACT".**

**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

**Hospice and Palliative Care in Colorado.** The bill repeals and reenacts the "Colorado Medical Treatment Decision Act". The term "artificial nourishment" replaces "artificial nutrition and hydration", the term "lacking decisional capacity" replaces "incompetent", and a new term, "persistent vegetative state", has been added in order to clarify different medical conditions under which the act shall be applied. The options available to the patient when he or she is in a terminal condition,

persistent vegetative state, or otherwise lacking decisional capacity are clarified. The bill removes from statute the legal form that the declaration as to medical or surgical treatment may take and makes further clarifications concerning the declaration. Any declaration executed in compliance with Colorado law at the time it was made shall continue to be an effective declaration, and any declaration executed in compliance with the laws of another state shall be considered effective in Colorado, granted that such declaration does not violate any Colorado law.

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

**SECTION 1.** Article 18 of title 15, Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

**ARTICLE 18**

**Colorado Medical Treatment Decision Act**

**15-18-101. Short title.** THIS ARTICLE SHALL BE KNOWN AND MAY BE CITED AS THE "COLORADO MEDICAL TREATMENT DECISION ACT".

**15-18-102. Legislative declaration.** (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT:

(a) COLORADO LAW HAS TRADITIONALLY RECOGNIZED THE RIGHT OF AN ADULT TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT;

(b) RECENT ADVANCES IN MEDICAL SCIENCE HAVE MADE IT POSSIBLE TO PROLONG THE DYING PROCESS THROUGH THE USE OF ARTIFICIAL, EXTRAORDINARY, EXTREME, OR RADICAL MEDICAL OR SURGICAL PROCEDURES;

(c) THE USE OF SUCH MEDICAL OR SURGICAL PROCEDURES INCREASINGLY INVOLVES PATIENTS WHO ARE IN A TERMINAL CONDITION, A PERSISTENT VEGETATIVE STATE, OR OTHERWISE LACKING DECISIONAL CAPACITY TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT;

(d) THE TRADITIONAL RIGHT TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT SHOULD BE AVAILABLE TO AN ADULT WHILE HE OR

SHE HAS DECISIONAL CAPACITY, NOTWITHSTANDING THE FACT THAT SUCH MEDICAL OR SURGICAL TREATMENT MAY BE OFFERED OR APPLIED WHEN HE OR SHE IS SUFFERING FROM A TERMINAL CONDITION, IS IN A PERSISTENT VEGETATIVE STATE, OR OTHERWISE LACKING DECISIONAL CAPACITY TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT;

(e) THIS ARTICLE AFFIRMS THE TRADITIONAL RIGHT TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT, AND CREATES A PROCEDURE BY WHICH AN ADULT WITH DECISIONAL CAPACITY MAY MAKE SUCH DECISIONS IN ADVANCE OF MEDICAL NEED;

(f) IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT NOTHING IN THIS ARTICLE SHALL HAVE THE EFFECT OF MODIFYING OR CHANGING CURRENTLY PRACTICED MEDICAL ETHICS OR PROTOCOL WITH RESPECT TO ANY PATIENT IN THE ABSENCE OF A DECLARATION AS PROVIDED FOR IN SECTION 15-18-104;

(g) IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT NOTHING IN THIS ARTICLE SHALL REQUIRE ANY ADULT TO EXECUTE A DECLARATION.

**15-18-103. Definitions.** AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ADULT" MEANS ANY PERSON EIGHTEEN YEARS OF AGE OR OLDER.

(2) "ARTIFICIAL NOURISHMENT AND HYDRATION" MEANS NOURISHMENT SUPPLIED THROUGH A TUBE INSERTED INTO THE STOMACH OR INTESTINES OR NUTRIENTS INJECTED INTRAVENOUSLY INTO THE BLOODSTREAM.

(3) "ATTENDING PHYSICIAN" MEANS THE PHYSICIAN, WHETHER SELECTED BY OR ASSIGNED TO A PATIENT, WHO HAS PRIMARY RESPONSIBILITY FOR THE TREATMENT AND CARE OF THE PATIENT.

(4) "COURT" MEANS THE DISTRICT COURT OF THE COUNTY IN

WHICH A DECLARANT HAVING A TERMINAL CONDITION IS LOCATED AT THE TIME OF COMMENCEMENT OF A PROCEEDING PURSUANT TO THIS ARTICLE OR, IF IN THE CITY AND COUNTY OF DENVER, THE PROBATE COURT.

(5) "DECISIONAL CAPACITY" MEANS THE ABILITY TO PROVIDE INFORMED CONSENT TO OR REFUSAL OF MEDICAL TREATMENT OR THE ABILITY TO MAKE AN INFORMED HEALTH CARE BENEFIT DECISION.

(6) "DECLARANT" MEANS AN ADULT POSSESSING DECISIONAL CAPACITY WHO EXECUTES A DECLARATION.

(7) "DECLARATION" MEANS A WRITTEN DOCUMENT VOLUNTARILY EXECUTED BY A DECLARANT IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 15-18-104.

(8) "HOSPITAL" MEANS AN INSTITUTION HOLDING A LICENSE OR CERTIFICATE OF COMPLIANCE AS A HOSPITAL ISSUED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT AND INCLUDES HOSPITALS OPERATED BY THE FEDERAL GOVERNMENT IN COLORADO.

(9) "LIFE-SUSTAINING PROCEDURE" MEANS ANY MEDICAL PROCEDURE OR INTERVENTION THAT, IF ADMINISTERED TO A QUALIFIED PATIENT, WOULD SERVE ONLY TO PROLONG THE DYING PROCESS, AND SHALL NOT INCLUDE ANY MEDICAL PROCEDURE OR INTERVENTION FOR NOURISHMENT OF THE QUALIFIED PATIENT OR CONSIDERED NECESSARY BY THE ATTENDING PHYSICIAN TO PROVIDE COMFORT OR ALLEVIATE PAIN. HOWEVER, ARTIFICIAL NOURISHMENT AND HYDRATION MAY BE WITHDRAWN OR WITHHELD PURSUANT TO SECTION 15-18-104 (4).

(10) "PERSISTENT VEGETATIVE STATE" IS DEFINED BY REFERENCE TO THE CRITERIA AND DEFINITIONS EMPLOYED BY PREVAILING COMMUNITY MEDICAL STANDARDS OF PRACTICE.

(11) "PHYSICIAN" MEANS A PERSON DULY LICENSED UNDER THE PROVISIONS OF ARTICLE 36 OF TITLE 12, C.R.S.

(12) "QUALIFIED PATIENT" MEANS A PATIENT WHO HAS EXECUTED A DECLARATION IN ACCORDANCE WITH THIS ARTICLE AND WHO HAS BEEN CERTIFIED BY THE ATTENDING PHYSICIAN AND ONE OTHER PHYSICIAN TO BE IN A TERMINAL CONDITION OR PERSISTENT VEGETATIVE STATE.

(13) "TERMINAL CONDITION" MEANS AN INCURABLE OR IRREVERSIBLE CONDITION FOR WHICH THE ADMINISTRATION OF LIFE-SUSTAINING PROCEDURES WILL SERVE ONLY TO PROLONG THE DYING PROCESS.

**15-18-104. Declaration as to medical treatment.** (1) ANY ADULT WITH DECISIONAL CAPACITY MAY EXECUTE A DECLARATION DIRECTING THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR WITHDRAWN IF, AT SOME FUTURE TIME, HE OR SHE IS IN A TERMINAL CONDITION, IS IN A PERSISTENT VEGETATIVE STATE, OR OTHERWISE LACKS DECISIONAL CAPACITY TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT. IT SHALL BE THE RESPONSIBILITY OF THE DECLARANT OR SOMEONE ACTING FOR THE DECLARANT TO PROVIDE THE DECLARATION TO THE ATTENDING PHYSICIAN OR ADVANCED PRACTICE NURSE FOR ENTRY IN THE DECLARANT'S MEDICAL RECORD.

(2) IN THE CASE OF A DECLARATION OF A QUALIFIED PATIENT KNOWN TO THE ATTENDING PHYSICIAN TO BE PREGNANT, A MEDICAL EVALUATION SHALL BE MADE AS TO WHETHER THE FETUS IS VIABLE AND COULD WITH A REASONABLE DEGREE OF MEDICAL CERTAINTY DEVELOP TO LIVE BIRTH WITH CONTINUED APPLICATION OF LIFE-SUSTAINING PROCEDURES. IF SUCH IS THE CASE, THE DECLARATION SHALL BE GIVEN NO FORCE OR EFFECT.

(3) (a) THE DECLARATION MAY CONTAIN SEPARATE WRITTEN STATEMENTS REGARDING THE DECLARANT'S PREFERENCE CONCERNING LIFE-SUSTAINING PROCEDURES AND ARTIFICIAL NOURISHMENT AND

HYDRATION IF THE DECLARANT IS IN A TERMINAL CONDITION OR IS IN A PERSISTENT VEGETATIVE STATE.

(b) THE DECLARANT MAY PROVIDE IN HIS OR HER DECLARATION ONE OF THE FOLLOWING ACTIONS:

(I) THAT ARTIFICIAL NOURISHMENT AND HYDRATION NOT BE CONTINUED;

(II) THAT ARTIFICIAL NOURISHMENT AND HYDRATION BE CONTINUED FOR A SPECIFIED PERIOD; OR

(III) THAT ARTIFICIAL NOURISHMENT AND HYDRATION BE CONTINUED.

(c) A DECLARATION EXECUTED PRIOR TO MARCH 29, 1989, MAY BE AMENDED BY A CODICIL TO INCLUDE THE PROVISIONS OF THIS SUBSECTION (3).

(4) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (3) OF THIS SECTION AND SECTION 15-18-103 (9), WHEN AN ATTENDING PHYSICIAN HAS DETERMINED THAT PAIN RESULTS FROM A DISCONTINUANCE OF ARTIFICIAL NOURISHMENT AND HYDRATION, THE PHYSICIAN MAY ORDER THAT NOURISHMENT AND HYDRATION BE CONTINUED TO THE EXTENT NECESSARY TO PROVIDE COMFORT AND ALLEVIATE PAIN.

(5) A DECLARATION EXECUTED BEFORE TWO WITNESSES BY ANY ADULT WITH DECISIONAL CAPACITY SHALL BE LEGALLY EFFECTIVE FOR THE PURPOSES OF THIS ARTICLE.

(6) ANY DECLARATION MADE PURSUANT TO THIS ARTICLE MAY ALSO HAVE A DOCUMENT WITH A WRITTEN STATEMENT AS PROVIDED IN SECTION 12-34-105 (a), C.R.S., OR A WRITTEN STATEMENT IN SUBSTANTIALLY SIMILAR FORM, INDICATING A DECISION REGARDING ORGAN AND TISSUE DONATION. SUCH A DOCUMENT SHALL BE EXECUTED

IN ACCORDANCE WITH THE PROVISIONS OF THE "REVISED UNIFORM ANATOMICAL GIFT ACT", ARTICLE 34 OF TITLE 12, C.R.S.

(7) ANY DECLARATION MADE PURSUANT TO THIS ARTICLE MAY ALSO BE COMBINED WITH A DOCUMENT OR WRITTEN STATEMENT DESIGNATING AN AGENT UNDER A MEDICAL POWER OF ATTORNEY. SUCH A DOCUMENT SHALL BE EXECUTED IN ACCORDANCE WITH THE PROVISIONS OF PART 5 OF ARTICLE 14 OF THIS TITLE AND IN ACCORDANCE WITH THE PROVISIONS OF THE "COLORADO PATIENT AUTONOMY ACT", SECTIONS 15-14-503 TO 15-14-509.

(8) ANY DECLARATION MADE PURSUANT TO THIS ARTICLE MAY ALSO CONTAIN A WRITTEN STATEMENT DESIGNATING INDIVIDUALS TO WHOM THE DECLARANT MAY GRANT THE AUTHORITY TO SPEAK WITH THE ATTENDING PHYSICIAN, ANY OTHER TREATING PHYSICIAN, OR OTHER MEDICAL PROFESSIONAL OF THE DECLARANT PRIOR TO FINAL DETERMINATION AS TO THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES, INCLUDING ARTIFICIAL NOURISHMENT AND HYDRATION. THE LISTING OF SUCH INDIVIDUALS IN THE DOCUMENT SHALL BE CONSIDERED TO BE CONSISTENT WITH THE PRIVACY REQUIREMENTS OF THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", 42 U.S.C. SEC. 1320d TO 1320d-8, AS AMENDED, REFERRED TO IN THIS SECTION AS "HIPAA", REGARDING WAIVER OF CONFIDENTIALITY. THIS SECTION SHALL CONTAIN LANGUAGE SUFFICIENT TO CONSTITUTE A HIPAA RELEASE SO THAT MEDICAL PROFESSIONALS MAY DISCUSS MEDICAL INFORMATION WITH THE PERSONS DESIGNATED BY THE DECLARANT. THE LISTING OF NAMES IN SUCH A DOCUMENT SHALL NOT CONSTITUTE APPOINTMENT OF ADDITIONAL AGENTS UNDER A MEDICAL POWER OF ATTORNEY.

(9) ANY DECLARATION MADE PURSUANT TO THIS ARTICLE MAY

ALSO CONTAIN A WRITTEN STATEMENT PROVIDING INDIVIDUAL MEDICAL DIRECTIVES FROM THE DECLARANT TO THE ATTENDING PHYSICIAN OR ANY OTHER TREATING MEDICAL PERSONNEL.

**15-18-105. Inability of declarant to sign.** (1) IN THE EVENT THAT THE DECLARANT IS PHYSICALLY UNABLE TO SIGN THE DECLARATION, IT MAY BE SIGNED BY SOME OTHER PERSON IN THE DECLARANT'S PRESENCE AND AT THE DECLARANT'S DIRECTION. THE OTHER PERSON SHALL NOT BE:

(a) THE ATTENDING PHYSICIAN OR ANY OTHER PHYSICIAN;

(b) AN EMPLOYEE OF THE ATTENDING PHYSICIAN OR HEALTH CARE FACILITY IN WHICH THE DECLARANT IS A PATIENT;

(c) A PERSON WHO HAS A CLAIM AGAINST ANY PORTION OF THE ESTATE OF THE DECLARANT AT HIS OR HER DEATH AT THE TIME THE DECLARATION IS SIGNED; OR

(d) A PERSON WHO KNOWS OR BELIEVES THAT HE OR SHE IS ENTITLED TO ANY PORTION OF THE ESTATE OF THE DECLARANT UPON THE DECLARANT'S DEATH EITHER AS A BENEFICIARY OF A WILL IN EXISTENCE AT THE TIME THE DECLARATION IS SIGNED OR AS AN HEIR AT LAW.

**15-18-106. Witnesses.** (1) THE DECLARATION SHALL BE SIGNED BY THE DECLARANT IN THE PRESENCE OF TWO WITNESSES. THE WITNESSES SHALL NOT INCLUDE ANY PERSON SPECIFIED IN SECTION 15-18-105.

(2) IF THE DECLARANT IS A PATIENT OR RESIDENT OF A HEALTH CARE FACILITY, THE WITNESSES SHALL NOT BE PATIENTS OF THAT FACILITY.

(3) THE DECLARATION MAY BE NOTARIZED. THE ABSENCE OF NOTARIZATION SHALL HAVE NO IMPACT ON THE VALIDITY OF THE DECLARATION.

**15-18-107. Withdrawal - withholding of life-sustaining procedures.** IN THE EVENT THAT AN ATTENDING PHYSICIAN IS PRESENTED

WITH AN UNREVOKED DECLARATION EXECUTED BY A DECLARANT WHOM THE PHYSICIAN BELIEVES HAS A TERMINAL CONDITION, IS IN A PERSISTENT VEGETATIVE STATE, OR OTHERWISE LACKS DECISIONAL CAPACITY TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT, THE ATTENDING PHYSICIAN SHALL ORDER THE DECLARANT TO BE EXAMINED BY ONE OTHER PHYSICIAN. IF BOTH PHYSICIANS FIND THAT THE DECLARANT HAS A TERMINAL CONDITION, IS IN A PERSISTENT VEGETATIVE STATE, OR OTHERWISE LACKS DECISIONAL CAPACITY TO ACCEPT OR REJECT MEDICAL OR SURGICAL TREATMENT, THEY SHALL CERTIFY SUCH FACT IN WRITING AND ENTER SUCH IN THE QUALIFIED PATIENT'S MEDICAL RECORD OF THE HOSPITAL IN WHICH THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES OR ARTIFICIAL NOURISHMENT AND HYDRATION MAY OCCUR, TOGETHER WITH A COPY OF THE DECLARATION. IF THE ATTENDING PHYSICIAN HAS ACTUAL KNOWLEDGE OF THE WHEREABOUTS OF EITHER THE QUALIFIED PATIENT'S AGENT UNDER A MEDICAL POWER OF ATTORNEY OR, WITHOUT REGARD TO ORDER, THE PATIENT'S SPOUSE, A PERSON DESIGNATED UNDER THE "COLORADO DESIGNATED BENEFICIARY AGREEMENT ACT", AS DESCRIBED IN ARTICLE 22 OF THIS TITLE, ANY OF HIS OR HER ADULT CHILDREN, A PARENT, SIBLING, OR ANY OTHER PERSON DESIGNATED IN WRITING BY THE QUALIFIED PATIENT, THE ATTENDING PHYSICIAN SHALL IMMEDIATELY MAKE A REASONABLE EFFORT TO NOTIFY AT LEAST ONE OF SAID PERSONS THAT A CERTIFICATE OF TERMINAL CONDITION HAS BEEN SIGNED. IF NO ACTION TO CHALLENGE THE VALIDITY OF A DECLARATION HAS BEEN FILED WITHIN FORTY-EIGHT HOURS AFTER THE CERTIFICATION IS MADE BY THE PHYSICIANS, THE ATTENDING PHYSICIAN SHALL THEN WITHDRAW OR WITHHOLD ALL LIFE-SUSTAINING PROCEDURES OR ARTIFICIAL NOURISHMENT AND HYDRATION PURSUANT TO THE TERMS OF THE

DECLARATION.

**15-18-108. Determination of validity.** (1) ANY PERSON WHO IS THE PARENT, ADULT CHILD, SPOUSE, DESIGNATED BENEFICIARY UNDER THE "COLORADO DESIGNATED BENEFICIARY AGREEMENT ACT", ARTICLE 22 OF THIS TITLE, OR ATTORNEY-IN-FACT UNDER A DURABLE POWER OF ATTORNEY OF THE QUALIFIED PATIENT MAY CHALLENGE THE VALIDITY OF A DECLARATION IN THE APPROPRIATE COURT OF THE COUNTY IN WHICH THE QUALIFIED PATIENT IS LOCATED. UPON THE FILING OF A PETITION TO CHALLENGE THE VALIDITY OF A DECLARATION AND NOTIFICATION TO THE ATTENDING PHYSICIAN, A TEMPORARY RESTRAINING ORDER SHALL BE ISSUED UNTIL A FINAL DETERMINATION AS TO VALIDITY IS MADE.

(2) (a) IN PROCEEDINGS PURSUANT TO THIS SECTION, THE COURT SHALL APPOINT A GUARDIAN AD LITEM FOR THE QUALIFIED PATIENT, AND THE GUARDIAN AD LITEM SHALL TAKE SUCH ACTIONS AS HE OR SHE DEEMS NECESSARY AND PRUDENT IN THE BEST INTERESTS OF THE QUALIFIED PATIENT AND SHALL PRESENT TO THE COURT A REPORT OF HIS OR HER ACTIONS, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS.

(b) (I) UNLESS THE COURT, FOR GOOD CAUSE SHOWN, PROVIDES FOR A DIFFERENT METHOD OR TIME OF NOTICE, THE PETITIONER, AT LEAST FIVE DAYS PRIOR TO THE HEARING, SHALL CAUSE NOTICE OF THE TIME AND PLACE OF HEARING TO BE GIVEN AS FOLLOWS:

(A) TO THE QUALIFIED PATIENT'S GUARDIAN OR CONSERVATOR, IF ANY, AND THE COURT-APPOINTED GUARDIAN AD LITEM; AND

(B) TO THE QUALIFIED PATIENT'S SPOUSE OR BENEFICIARY UNDER THE "COLORADO DESIGNATED BENEFICIARY AGREEMENT ACT", ARTICLE 22 OF THIS TITLE, IF THE IDENTITY AND WHEREABOUTS OF SUCH PERSON IS KNOWN TO THE PETITIONER, OR OTHERWISE TO AN ADULT CHILD OR PARENT OF THE QUALIFIED PATIENT.

(II) NOTICE AS REQUIRED IN THIS PARAGRAPH (b) SHALL BE MADE IN ACCORDANCE WITH THE COLORADO RULES OF CIVIL PROCEDURE.

(c) THE COURT MAY REQUIRE EVIDENCE, INCLUDING INDEPENDENT MEDICAL EVIDENCE, AS IT DEEMS NECESSARY.

(3) UPON A DETERMINATION OF THE VALIDITY OF THE DECLARATION, THE COURT SHALL ENTER ANY APPROPRIATE ORDER.

(4) ANY DECLARATION EXECUTED IN COMPLIANCE WITH THE REQUIREMENTS OF COLORADO LAW IN EFFECT AT THE TIME THE DECLARATION WAS MADE SHALL CONTINUE TO BE AN EFFECTIVE DECLARATION AFTER THE EFFECTIVE DATE OF THIS ARTICLE, AS AMENDED.

(5) ANY DECLARATION EXECUTED IN COMPLIANCE WITH THE LAWS OF THE STATE IN WHICH THE DECLARATION WAS EXECUTED SHALL BE CONSIDERED EFFECTIVE FOR USE WITHIN THE STATE OF COLORADO TO THE EXTENT THAT SUCH DECLARATION DOES NOT VIOLATE ANY LAWS OF THE STATE OF COLORADO.

**15-18-109. Revocation of declaration.** A DECLARATION MAY BE REVOKED BY THE DECLARANT ORALLY, IN WRITING, OR BY BURNING, TEARING, CANCELLING, OBLITERATING, OR DESTROYING SAID DECLARATION.

**15-18-110. Liability.** (1) WITH RESPECT TO ANY DECLARATION THAT APPEARS ON ITS FACE TO HAVE BEEN EXECUTED IN ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE:

(a) ANY PHYSICIAN MAY ACT IN COMPLIANCE WITH SUCH DECLARATION IN THE ABSENCE OF ACTUAL NOTICE OF REVOCATION, FRAUD, MISREPRESENTATION, OR IMPROPER EXECUTION;

(b) NO PHYSICIAN SIGNING A CERTIFICATE OF TERMINAL CONDITION OR WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING PROCEDURES IN COMPLIANCE WITH A DECLARATION SHALL BE SUBJECT TO

CIVIL LIABILITY, CRIMINAL PENALTY, OR LICENSING SANCTIONS THEREFOR;

(c) A HOSPITAL OR PERSON ACTING UNDER THE DIRECTION OF A PHYSICIAN AND PARTICIPATING IN THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES IN COMPLIANCE WITH A DECLARATION SHALL NOT BE SUBJECT TO CIVIL LIABILITY, CRIMINAL PENALTY, OR LICENSING SANCTIONS THEREFOR.

**15-18-111. Determination of suicide or homicide - effect of declaration on insurance.** THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES FROM A QUALIFIED PATIENT PURSUANT TO THIS ARTICLE SHALL NOT, FOR ANY PURPOSE, CONSTITUTE A SUICIDE OR A HOMICIDE. THE EXISTENCE OF A DECLARATION SHALL NOT AFFECT, IMPAIR, OR MODIFY ANY CONTRACT OF LIFE INSURANCE OR ANNUITY OR BE THE BASIS FOR ANY DELAY IN ISSUING OR REFUSING TO ISSUE AN ANNUITY OR POLICY OF LIFE INSURANCE OR ANY INCREASE OF THE PREMIUM THEREFOR. NO INSURER OR PROVIDER OF HEALTH CARE SHALL REQUIRE ANY PERSON TO EXECUTE A DECLARATION AS A CONDITION OF BEING INSURED FOR OR RECEIVING HEALTH CARE SERVICES, NOR SHALL THE FAILURE TO EXECUTE A DECLARATION BE THE BASIS FOR ANY INCREASED OR ADDITIONAL PREMIUM FOR A CONTRACT OR POLICY FOR MEDICAL OR HEALTH INSURANCE.

**15-18-112. Application of article.** (1) NOTHING IN THIS ARTICLE SHALL BE CONSTRUED AS ALTERING OR AMENDING THE STANDARDS OF THE PRACTICE OF MEDICINE OR ESTABLISHING ANY PRESUMPTION, ABSENT A VALID DECLARATION, NOR AS CONDONING, AUTHORIZING, OR APPROVING EUTHANASIA OR MERCY KILLING, NOR AS PERMITTING ANY AFFIRMATIVE OR DELIBERATE ACT OR OMISSION TO END LIFE, EXCEPT TO PERMIT NATURAL DEATH AS PROVIDED IN THIS ARTICLE. NOTHING IN THIS ARTICLE SHALL REQUIRE THE PROVISION OR CONTINUATION OF MEDICAL

TREATMENT CONTRARY TO THE STANDARDS OF THE PRACTICE OF MEDICINE.

(2) DIAGNOSIS OF PERSISTENT VEGETATIVE STATE IS PERFORMED BY QUALIFIED MEDICAL PROFESSIONALS ACCORDING TO STANDARDS OF THE PRACTICE OF MEDICINE. NOTHING IN THIS ARTICLE, INCLUDING THE DEFINITION OF "PERSISTENT VEGETATIVE STATE" IN SECTION 15-18-103 (10) SHALL BE INTERPRETED TO DEFINE "PERSISTENT VEGETATIVE STATE" IN CONTRADICTION OF STANDARDS OF THE PRACTICE OF MEDICINE.

(3) IN THE EVENT OF ANY CONFLICT BETWEEN THE PROVISIONS OF THIS ARTICLE, OR A DECLARATION EXECUTED UNDER THIS ARTICLE, AND THE PROVISIONS OF SECTION 15-14-501, THE PROVISIONS OF THIS ARTICLE AND THE DECLARATION SHALL PREVAIL.

(4) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (3) OF THIS SECTION, THE DECLARANT MAY INCLUDE WITHIN THE DECLARATION OR WITHIN ANY POWER OF ATTORNEY EXECUTED BY THE DECLARANT A WRITTEN STATEMENT TO THE EFFECT THAT THE AGENT UNDER POWER OF ATTORNEY MAY OVERRIDE THE PROVISIONS OF THE DECLARATION.

**15-18-113. Refusal - transfer.** AN ATTENDING PHYSICIAN WHO REFUSES TO COMPLY WITH THE TERMS OF A DECLARATION VALID ON ITS FACE SHALL TRANSFER THE CARE OF THE DECLARANT TO ANOTHER PHYSICIAN WHO IS WILLING TO COMPLY WITH THE DECLARATION. REFUSAL OF AN ATTENDING PHYSICIAN TO COMPLY WITH A DECLARATION AND FAILURE TO TRANSFER THE CARE OF THE DECLARANT TO ANOTHER PHYSICIAN SHALL CONSTITUTE UNPROFESSIONAL CONDUCT AS DEFINED IN SECTION 12-36-117, C.R.S.

**SECTION 2. Act subject to petition - effective date.** This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August

11, 2010, if adjournment sine die is on May 12, 2010); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall not take effect unless approved by the people at the general election to be held in November 2010 and shall take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

**BILL E**

LLS NO. 10-0251.01 Jerry Barry **SENATE BILL**

**SENATE SPONSORSHIP**

**Tochtrop,** Newell, Williams

**HOUSE SPONSORSHIP**

**Soper,** Riesberg, Roberts, Tyler

**Senate Committees** **House Committees**

## A BILL FOR AN ACT

**CONCERNING MEDICAID PAYMENTS FOR INPATIENT CARE FOR HOSPICE RECIPIENTS.**

### Bill Summary

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

**Hospice and Palliative Care in Colorado.** Subject to the receipt of any necessary federal authorization, the act requires the department of health care policy and financing (department) to pay a nursing facility directly for inpatient services provided to a medicaid recipient who elects to receive hospice care rather than paying the hospice provider who then pays the nursing facility.

The act directs the department, subject to the receipt of sufficient

gifts, grants, or donations, to pay the state's costs of preparing the request to seek federal authorization to pay the nursing facility directly. The act specifies that such gifts, grants, or donations shall be deposited into the hospice care account in the department of health care policy and financing cash fund and may be used only for the state's costs of preparing the request.

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

**SECTION 1.** 25.5-5-304, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

**25.5-5-304. Hospice care.** (3) (a) SUBJECT TO THE RECEIPT OF ANY NECESSARY FEDERAL AUTHORIZATION, FOR A PERSON WHO HAS EXECUTED THE WAIVER DESCRIBED IN PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION AND WHO IS A RESIDENT IN A CLASS I FACILITY, AS DEFINED IN SECTION 25.5-6-201 (13), THE CLASS I FACILITY SHALL BILL THE STATE DEPARTMENT AND THE STATE DEPARTMENT SHALL PAY THE CLASS I FACILITY FOR THE ROOM AND BOARD COSTS OF THE PERSON.

(b) (I) IF REQUIRED, THE STATE DEPARTMENT SHALL SEEK THE APPROPRIATE FEDERAL AUTHORIZATION, CONDITIONED ON THE RECEIPT OF GIFTS, GRANTS, OR DONATIONS SUFFICIENT TO PROVIDE FOR THE STATE'S ADMINISTRATIVE COSTS OF PREPARING AND SUBMITTING THE REQUEST, TO MAKE THE PAYMENT DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3).

(II) THE STATE DEPARTMENT IS AUTHORIZED TO SEEK AND ACCEPT GIFTS, GRANTS, OR DONATIONS FROM PRIVATE OR PUBLIC SOURCES FOR THE PURPOSE OF PROVIDING FOR THE ADMINISTRATIVE COSTS OF PREPARING AND SUBMITTING THE REQUEST FOR FEDERAL APPROVAL FOR THE PAYMENTS DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3). ALL SUCH PRIVATE AND PUBLIC FUNDS RECEIVED THROUGH GIFTS,

GRANTS, OR DONATIONS SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE HOSPICE CARE ACCOUNT IN THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING CASH FUND CREATED PURSUANT TO SECTION 25.5-1-109, WHICH ACCOUNT IS HEREBY CREATED. MONEYS IN THE ACCOUNT SHALL BE SUBJECT TO APPROPRIATION AND SHALL ONLY BE USED FOR THE PURPOSES DESCRIBED IN THIS SUBPARAGRAPH (II).

**SECTION 2. Act subject to petition - effective date.** This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 11, 2010, if adjournment sine die is on May 12, 2010); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall not take effect unless approved by the people at the general election to be held in November 2010 and shall take effect on the date of the official declaration of the vote thereon by the governor.