Stakeholder Engagement Questions
July 8, 2026

RESPONSE FROM COALITION FOR COMPASSIONATE CARE OF CALIFORNIA, 7/15/2026

- **Geographic Service Area and Unmet Need**
  Part of the calculation to determine unmet need in a geographic service area is based on the number of patients a hospice can provide services for. The CA Hospice Audit identified the average daily capacity for hospice agencies to be 56 patients per day (excluding LA County due to the prevalent fraudulent activity).

  A stakeholder comment received states "the calculated daily capacity of 56 tells us nothing about whether there is hospice service capacity over a course of year to care for the likely hospice-eligible patients in the county."

  Question #1: What alternative data source or publication should the Department use to more accurately capture the average hospice agency patient count per year? Please provide details on your suggested approach to determining a hospice's service capacity.

CCCC Response: The CalHHS dataset on home health and hospice contains detailed data on each hospice agency's admissions, discharges, and deaths. However, **determining hospice service capacity is not an essential step in determining unmet need.** See our next response.

Question #2: Do you have additional comments or suggestions related to Geographic Service are or unmet need that you would like to provide?

CCCC Response: The simplest method for establishing need for hospice services in a given county is to look at the current data on hospice utilization in the county and compare it to statewide averages. Specifically, for simplicity if not absolute completeness, take the number of Medicare beneficiaries who died while receiving hospice care in the county in the most recent year and divide it by the total number of Medicare beneficiaries in the county to yield a hospice utilization percentage. (This will not capture all hospice deaths, as some hospice patients are not receiving or eligible for Medicare, but it is a useful gauge.) Since 2020, the *national* average percentage of Medicare beneficiaries receiving any hospice care prior to death has hovered around 50%, within a range of 27.3% in New York to 65.6% in Utah. California's average in 2024 was 45.7% (based on data compiled by Hospice Analytics). **If hospice utilization in a given county falls below that percentage, or more conservatively, below 40%, there is likely unmet need for hospice services.**

This simple method for calculating need for hospice services is used by a number of "certificate of need" states: For instance: Alabama: unmet need if <40% hospice utilization; Arkansas: unmet need if <30% hospice utilization; Kentucky: unmet need if hospice utilization is <80% of statewide median hospice utilization rate (using a weighted 3-year average); Tennessee: unmet need if hospice utilization is <80% of statewide median hospice utilization rate (using a weighted 3-year average).

❖ **Medical Director**

Pursuant to Title 22 CCR section 74856(b)(2), the hospice Medical Director must have a minimum of two years of **full-time** supervisory or managerial experience in a hospice, home health agency, or providing palliative care to patients within the last five years. The Department has received comments suggesting that full-time supervisory experience is unrealistic because many Medical Directors only work part-time.

Question #3: Should the regulations be updated to allow part-time or full-time experience for hospice Medical Directors? Is there an alternative measure that the Department should consider instead?

CCCC Response: **Absolutely, yes!** This requirement will make it extremely difficult for small and even medium-sized hospices in any setting to find TWO qualified physicians for these roles. In our comment letter of 6/16/2026, we made the **following recommendations for Medical Director/Designee qualifications:**

Medical directors should hold a current, unrestricted license to practice medicine in California AND

- Demonstrate a minimum of 400 hours of broad hospice- or palliative-care related experience, OR
- A minimum of 2 years full-time or part-time supervisory or managerial experience in a hospice, home health agency, or providing palliative care to patients; OR
- Three years full or part-time experience providing direct patient care in hospice, home health, or palliative care within the last five years; OR
- Hold an ABMS Certificate of Added Qualification in hospice and palliative medicine; OR
- Hold a certification as a Hospice Medical Director through the Hospice Medical Directors Certification Board.

We would also recommend that hospice Medical Directors must be certified as a Hospice Medical Director or board certified in Hospice and Palliative Medicine, but with an allowed timeframe for compliance of up to 3 years for currently licensed hospices.

Finally, **we would request that the Department make clear that the qualification requirements do not apply to existing staff of hospices with active licenses.** It is unreasonable to ask hospices to terminate staff in good standing based on brand-new pre-hire qualifications. The same clarification should be made for the Director of Patient Care Services/Designee and Administrator/Designee.

The regulations currently prohibit a Medical Director from having concurrent employment with more than one hospice; with the exception that they may be employed by up to three hospices in the same rural area. The Department has received requests to increase the agency limit for Medical Directors to a maximum of 3 hospice agencies in all areas, not just rural areas.

Question #4: Should the Department consider increasing the limit to allow Medical Directors (and their designees) to concurrently work at 3 hospice agencies? Please share any studies or information that supports making this change.

CCCC Response: **Yes!** As noted in our comment letter of 6/16/2026: In California there are many very small hospices (serving <50 or even <20 patients) operating in urban as well as rural areas. These hospices must (by regulation and by best practice) have a medical director, but they will be hard pressed to afford a full-time contract with any qualified physician. Hospice Medical Directors may spend as little as 10 hours per month on supervisory/management activities for a small or very small hospice. Limiting medical directors to employment with only one hospice outside of a rural area will make it very difficult for these very small hospices to obtain the services of a qualified Medical Director, let alone also a medical director designee. **We recommend that the regulations allow Medical Directors to contract concurrently with a maximum of 3 hospices, whether in rural or urban areas.**

We further note that California regulations impose no limitation on the number of skilled nursing facilities with which a medical director may be employed or contracted.

Regarding studies, we don't believe it is the responsibility of stakeholders to conduct or research workforce analyses that should have been performed by the state prior to imposing rigorous requirements for staff qualifications.

- **Administrator**
  The regulations require all hospice Administrators and Administrator Designees to hold a baccalaureate degree or higher in a health-related field.

  Question #5: Should eligibility as a hospice Administrator or Administrator Designee be limited to applicants with health-related baccalaureate degrees? If not, what other types of degrees should be permitted?

  Question #6 Should the Department consider experience in lieu of the baccalaureate degree as an alternative pathway to establishing eligibility to serve as the Administrator or Administrator Designee?

  Question #7: Do you have additional comments or suggestions related to hospice leadership positions and qualifications that you would like to provide?

CCCC Response: Administrators run the business side of hospice organizations, so requiring a health-related baccalaureate degree is inappropriate. Business-related degrees are certainly relevant, but many other degrees would be equally applicable. Many nurses and other health professionals with long, high-performing careers who have risen to management positions do not possess any bachelor's degree at all. **For the administrator position, experience is far more important than any particular academic preparation.** We would further recommend that whatever requirements are stated, they **should apply only to new hires or newly licensed facilities, and that administrators in good standing for hospices with active licenses who do not meet the requirements can remain in their roles.** Again, it is unreasonable to ask hospices to terminate staff in good standing based on brand-new pre-hire qualifications.

- **Change of Locations (CHOL)**
  Current emergency regulations under section 74828(a)(2) require hospice agencies to submit an application to the Department at least 60 days prior to

an anticipated change in location. Some commenters indicate that this timeframe is unrealistic as landlords are unlikely to hold space.

Question #8: Should the Department consider an alternative timeframe for reporting changes of location? What timeframe would you recommend?

CCCC Response: We have no opinion on this issue, but will note that many of our members have expressed concern based on the leasing issues noted.

- **OTHER**
  The authority to develop emergency regulations specified the scope of what could be included as part of the emergency rulemaking. As the Department moves into regular rulemaking, we have the opportunity to address additional content areas.

  Question #9: Are there other topics that CDPH should consider in establishing permanent regulations for hospice agencies?

CCCC Response: **Yes: Here are some recommendations:**

Quality measures. Currently, hospices are "required" by federal regulation to report quality measures, subject to a financial penalty. More than two-thirds of hospices in California, however, report no quality measures at all, preferring to pay the penalty. Without some comparative quality data for hospices, patients and families, as well as other healthcare providers referring patients to hospice care, cannot make informed choices about hospice agencies, especially when the timeframe of service is typically short and the opportunities to resolve problems or change providers very few. **We strongly urge CDPH to include a requirement that all hospices, in order to obtain or renew their license, without exception or exemption, publicly report hospice quality measures per the Centers for Medicare & Medicaid Services data collection recommendations/requirements.**

Telehealth and telephone support. There is not a single mention in the regulations of the use of telehealth (e.g., health-related communication and "visits" via audio/video, remote patient monitoring). Especially in very rural areas, such technologies are used effectively to widen service areas, reduce response time, and maintain supportive contact with patients. **We recommend explicit incorporation of telehealth and remote patient support into hospice regulatory guidance.** Telehealth is a critical tool to improve access, reduce response times, and support continuity of care, particularly in rural and geographically dispersed areas. Clear regulatory alignment will enable safe and appropriate use of these modalities.

Volunteer and Bereavement programs. The use of volunteers and provision of bereavement services are mandated by federal hospice conditions of participation and yet are often activities that are short-changed or virtually absent in low-quality, profit-motivated agencies. We therefore **urge CDPH to include a requirement that all licensed hospices demonstrate full adherence to the federal requirements with respect to volunteer hours and bereavement programs.** Also, **specific definition, above a rock-bottom level, of what constitutes a bereavement "program" with respect to staffing, services, and content should be articulated in the regulations.**

Multiple licenses. While we recognize that some hospice owners have "branches" that may require multiple licenses, we would **recommend that there be either a maximum**

number smaller than 10 on the total number of licenses per owner or a limit on the number of licenses that can be obtained in a given timeframe (e.g., 5 years).

> **Question #10**: Please provide any comments you have regarding the hospice regulations in general.

CCCC Response: In general, we applaud and support the Department's efforts to address serious problems in the delivery of hospice care. However, we would **urge an ongoing openness to hear the feedback of the stakeholders and to correct/adjust regulations to avoid adverse consequences.** Regulatory changes must both strengthen oversight and avoid unintended reductions in access or continuity of care. Overly rigid requirements related to staffing, service areas, and licensure may inadvertently restrict access by causing smaller hospice agencies to close altogether, and may delay hospice enrollment for seriously ill patients, especially in rural communities.