



June 16, 2026

MEMO

TO: OFFICE OF ADMINISTRATIVE LAW

FR: JENNIFER MOORE BALLENTINE, CEO
ON BEHALF OF COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

RE: DPH-18-002E, Hospice Emergency Regulations, June 2026

Sustaining Supporters

Alliance of Catholic Health Care
Cedars-Sinai Medical Center
Sharp HealthCare
Blue Shield of California
Emanate Health
YoloCares

Thank you for the opportunity to provide written comments on behalf of the Board of Directors and Public Policy Advisory Council of the Coalition for Compassionate Care of California (CCCC). Established in 1998, CCCC is a cross-sector, nonprofit membership organization focused on improving the quality, delivery, and experience of serious illness and end-of-life care in California. Our 100+ organizational members comprise health systems, health plans, healthcare facilities and agencies of all kinds, and more than 200 dedicated members of the professional and public communities.

First, **we want to thank the Center for Health Care Quality and the California Department of Public Health for working to address the serious issues that have degraded hospice quality and care** in the state for a number of years. The proposed regulations are comprehensive, responsive to the issues, and obviously reflect hard work and commitment from many entities and individuals.

From a population health perspective, ensuring timely access to high-quality hospice services is critical. 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 and may delay hospice enrollment for seriously ill patients, in rural communities.

Thus, there are a few matters that we feel require additional attention and possible modification, **ideally prior to implementation**, which are detailed below:

1. General observation/question regarding compliance by existing hospices
2. Limit on number of licenses per owner
3. Patient's representative (as defined, not able to sign advance directives at admission)
4. Geographic Service Area (2-hour radius from parent location does not account for branch locations or strategically situated staff members)
5. Unmet need calculation/demonstration (serious math and conceptual errors in calculations)
6. Assignment of maximum 12 patients per licensed nurse (ratio too low and too rigid)
7. Patient acuity system (lack of consistency and rigor in model; feasibility of implementation)
8. Qualifications and experience of Hospice Medical Director (unrealistic given current workforce shortages)

9. Limitations on contracting/employment for Medical Director (may unfairly impact small hospices in both rural *and* urban areas)
10. Admission of unrepresented patients (no provision made for consent to enroll)
11. Hospice Management Orientation and Annual Training Requirements (recommend allowance for recently completed equivalent/accredited training prior to hire)
12. Plan of Correction implementation (needs more rigorous timeline and verification)
13. Additional comments/recommendations (re: telehealth, quality measures, volunteer and bereavement programs).

Specific comments/recommendations:

1. General observation/question regarding compliance by existing hospices.

It is unclear to us at what point, and how, currently licensed hospices will be required to comply with the new regulations, in particular the qualification/experience requirements for management personnel, the measured geographical service area, and the justifications for unmet need in counties served by the hospice. It is also unclear whether currently licensed and operating hospices would be required to comply in every respect to the regulations or whether some deviations from the requirements might be “grandfathered.” Expecting all hospices to comply with these new regulations in every particular immediately is unreasonable, burdensome, and may have the unintended consequence of requiring programs to close, further limiting access to quality care.

In particular, **we recommend that requirements regarding geographic service area, calculation or unmet need for every county currently being served, the 1:12 nurse:patient ration, and prior work experience requirements for key staff should have some flexibility or timeline to allow for full compliance.** Alternatively, hospices that already have State-approved and established service areas, and that have been caring for their communities since prior to 2000, could have their service areas and programs, grandfathered as-is.

We also **urge CDPH to develop and deliver educational and technical assistance programs** to ensure all hospices are aware of the regulations, understand the timeline for compliance and opportunities for further comment, and have a forum in which to ask clarifying questions.

2. Limit on number of licenses per owner.

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).**

3. Patient’s representative (§74800(a)(45). Definitions, p. 7) and (§74860 3(A) & 3(B), Admission, p. 57)

As defined, the patient’s representative is NOT legally authorized to sign a patient’s advance directives at admission (§74860 3(A) & 3(B), Admission, p. 57). Only a patient can sign their own advance health care directive, and only a legally authorized surrogate decisionmaker can sign a POLST or out-of-hospital DNR on behalf of an incapacitated patient (see CA Probate Code, Div. 4.7 Health Care Decision, Pt. 2,

Uniform Health Care Decisions Act, [Chapter 3 Health Care Surrogates](#)). **This section of the proposed hospice regulations should be edited to read:**

(3) Pursuant to subdivision (e)(2), at the time of admission the hospice must include in the patient's medical record either:

(A) A copy of the advance **health care** directive prepared and signed by the patient or ~~the patient's representative~~ **advance medical order such as POLST or prehospital DNR signed by the patient or the patient's legally authorized surrogate decisionmaker.**

(B) A document signed by the patient or the patient's representative acknowledging that the patient does not have any advance **health care** directives **or advance medical orders** at the time of admission, but the hospice has provided the patient with written materials explaining the hospice's policies relating to advance directives **and medical orders** and information regarding the benefits of advance directives **and medical orders.**

4. Geographic Service Area (§74820(a) et seq., Geographic Service Area, p. 25)

The proposed regulations require hospices to limit a geographic service area to within a radius of the ability of hospice personnel (specifically, a nurse) to respond in person to a patient's need within 2 hours, as measured from the "parent hospice's address as indicated on the application for hospice licensure." We wish to note that many hospices maintain branch or satellite locations, which may extend the response radius beyond 2 hours from the *parent* location or, in the case of after-hours response, employ nurses whose homes' locations may extend the response radius. **We recommend that the provisions be modified to allow for response times from branch or satellite locations or when staff travel directly from their homes to patient locations during or after regular business hours.**

5. Unmet need calculation/demonstration (§74820, (3)(e)–(g), Geographic Service Area, pp. 25–27)

We applaud the requirement that need for hospice services must be demonstrated in the application for a new hospice license, however, **the proposed formula to determine need is both mathematically incorrect and conceptually flawed. It contains a serious mathematical error that will result in gross underestimates, by about 50%, of potentially hospice-eligible patients in a given county.** The Finding of Emergency document's discussion of the formula notes that cancer is (according to 2020 NHPCO statistics¹) the leading principal diagnosis among Medicare hospice patients, accounting for **30% of all hospice admitting diagnoses**. Cancer deaths are thus selected as the identifiable cause of death for the formula in subdivision (f)(1)(B)(v). Subdivision (f)(1)(C) calculates an average annual number of people who died from cancer for the identified county, representing in theory 30% of all hospice-eligible patients. Subdivision (f)(a)(D) instructs us to calculate the remaining 70% of possible hospice-eligible diagnoses by multiplying the average annual number of cancer deaths by 0.7; and then in subdivision (f)(a)(E), adding that value to the average annual number of cancer deaths. A final step in subdivision

¹ We note that the statistics of hospice admissions by diagnosis are 6 years out of date and, according to more current information from the same source, the [NHPCO annual Facts & Figures 2025 edition](#), cancer is no longer the leading hospice diagnosis at just 22% of the total. Circulatory disorders, including heart failure, were the leading category at 30%, followed by neurovascular disorders, including Alzheimer's disease and dementias at 25%.

(f)(a)(F), divides the total by 0.5 on the assumption that about half of all hospice-eligible patients are likely to actually seek or receive services. OR:

$$(\text{Cancer deaths} \times 0.7) + \text{Cancer deaths} = \text{All potential hospice patients}$$

$$((\text{Cancer deaths} \times 0.7) + \text{Cancer deaths}) \times .5 = \text{All likely hospice-eligible patients}$$

Taking, for example, Sacramento county, using the data specified, the average annual cancer deaths (2014–2024) in the county is 2,575. By this formula, the remaining number of people with hospice-eligible diagnoses would be 1,803; the total number of potential hospice patients in the county would be 4,378; and the total likely hospice-eligible patients would be 2,189. In three steps:

$$(2575 \times 0.7) = 1803$$

$$1803 + 2575 = 4378$$

$$4378 \times .5 = 2189$$

However, **1,803 is 70% of the CANCER patients, not 70% of the total number of potential hospice patients.**

Using the underlying assumption that cancer patients constitute 30% of all hospice patients, **to get from the average annual number of cancer patients to the total number of potential hospice patients, one would simply need to multiply the cancer patients by 3.33, not 0.7:**

$$(\text{Cancer deaths} \times 3.33) = \text{All potential hospice patients}$$

$$((\text{Cancer deaths} \times 3.33) \times .5) = \text{All likely hospice-eligible patients}$$

That result added to the cancer deaths yields the correct estimate of all potential hospice patients in Sacramento county as 8,575; and the total estimate of likely hospice-eligible patients would be 4,287, not 2,189. OR, in two steps:

$$(2575 \times 3.33) = 8575$$

$$8575 \times .5 = 4287$$

The same calculations for San Diego county would be:

INCORRECT:

$$(5055 \times 0.7) = 3539$$

$$3539 + 5055 = 8594$$

$$8594 \times .5 = \mathbf{4297}$$

CORRECT:

$$5055 \times 3.33 = 16833$$

$$16833 * .5 = \mathbf{8417}$$

In addition, because the formula relies solely on residential deaths, it **misses a substantial number of hospice patients who died in facilities**, either as their primary residence or inpatient for acute symptom management (GIP level of care). For example, from the [HCAI Hospice Utilization table](#)) shows the following for 2023:

- Sacramento: 1,996 home + 483 facility = 2,479
- San Diego: 3,965 home + 825 facility = 4,790
- Yolo: 238 home + 63 facility = 301

The next step in the calculation attempts to estimate the average number of patients that all currently licensed hospices in the county are able to serve. **The proposed formula for this step also grossly underestimates the service capacity of currently licensed hospices.** The first flaw here is that a given county may be *served by* hospices that are *licensed in* an adjacent county, so **the *N* of hospices is already likely to be wrong.** For instance, the Cal Health database lists only one hospice licensed in Yolo County, whereas the [National Hospice Locator](#) database lists 9 hospices serving the county.

Based on an estimate made in the [Audit Report](#), the Department has concluded that “56 patients per hospice” should be used as the “average standard” to calculate service capacity. Neither the regulations nor the Finding of Emergency document annotations specify whether that is 56 patients *per day, per month, per year, or any timeframe*. The Audit Report, however, states this estimate at “56 patients per hospice agency per day.”

Multiplying the number of hospices licensed in a given county by 56 yields an estimate of capacity ON ANY GIVEN DAY, whereas the calculation of likely hospice-eligible patients yields an estimate of the number of patients likely to utilize hospice over the course of A YEAR. The context timeframes are not equivalent; therefore, the numbers have no logical relationship to each other. One can’t determine whether a DAILY capacity to care for *X* patients will accommodate *Y* number of patients over a course of year. By the Department’s formula, the entire service capacity in Yolo county would be 56 patients. 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, whether that is 249 (by the incorrect formula) or 488 (by the corrected formula).

Furthermore, the sum of the lowest numbers in the ranges of average daily census (ADC) for all 9 hospices serving Yolo county would put the daily capacity of service at more than 700, not 56. **Any estimation of a county’s hospice capacity must take into account not only the number of hospices licensed in the county, but the number of hospices serving the county while licensed in a different county, and some proportion of the total actual average daily censuses of those hospices.**

We believe the entire formula to calculate unmet need to be not only mathematically wrong but conceptually flawed and a very bad basis on which to calculate need for hospices services. The formula, correctly or incorrectly calculated, does not include patients in facilities nor does it include any consideration of special populations such as pediatric or unhoused patients that may not be readily accepted by area hospices.

Finally, addressing only “need” does not guarantee quality. In a given county, for instance, the “need” for hospice services might be met by existing agencies, but what if the existing agencies are all or mostly of very poor quality? **We recommend that a demonstration/calculation of “unmet need” also allow for a demonstration of poor quality for a given service area, based on objective, publicly reported quality measures.**

6. Assignment of maximum 12 patients per licensed nurse (§74848(b). Nursing, p. 47)

A caseload ratio of 1:12 (1 licensed nurse with primary responsibility for the patients within the nurse’s scope of practice to 12 patients) may be optimal, but we feel it is too rigid and unrealistic given current constraints on the nursing workforce in general and on the pool of nurses trained to care for hospice patients in particular. Hospice census and staffing levels are subject to fluctuation: a sudden spike in census or deficit in staffing or change in the distribution (e.g., in facilities or at home) or acuity of patients will all play into daily nurse:patients ratios. Following the source cited in the Finding of Emergency document, the BerryDunn report, **we would recommend a more flexible ratio of 1:13–18 to allow for such fluctuations while still ensuring high-quality care. We would also recommend that licensed vocational nurses (LVNs) not be considered in this regulation. Flexibility must be paired with minimum quality thresholds.**

7. Patient acuity system (§74848(f)–(i). Nursing, pp. 47–49)

Adjusting staffing to account for patient acuity is good practice, as is having a defensible and regularly reviewed system for determining it. However, there is no currently available validated patient acuity system. Leaving the development of the system up to each individual hospice risks inconsistencies in service and real complications for any evaluation of its value by surveyors or regulators. Furthermore, use of a patient acuity system to determine staffing needs seems to be in contradiction with a strict nurse:patients ratio. **We would recommend delaying imposition of this requirement and instead convening a taskforce of industry experts to work collaboratively to develop and validate a consistent patient acuity system that can be used across the state.**

8. Qualifications and experience of Hospice Medical Director (§74856(b). Medical Director, p. 53)

The proposed regulations require that 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.” Given that there are very few physicians working full time in supervisory/managerial roles in hospice, home health, or palliative care, we believe this is an unrealistic expectation. **We would recommend that instead that medical directors 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.

9. Limitations on contracting/employment for Medical Director (§74856(f),(g). Medical Director, p. 53)

The Medical Director “must not have concurrent employment with other hospices” but “may be concurrently employed or contracted by no more than three hospices only if all hospices are located in the same rural area.” We note that 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. **We recommend that the regulations allow Medical Directors to contract concurrently with a maximum of 3 hospices, whether in rural or urban areas.**

10. Admission of unrepresented patients. (§74860(3)(b). Admission, p. 55).

These regulations do not make any provision for the admission of incapacitated patients who lack a “representative.” **We would recommend that hospice-eligible patients who cannot consent to hospice care be admitted, without recourse to the courts, if the hospice medical director and a second physician (e.g., patient’s attending physician or hospitalist) certify terminal illness.**

11. Hospice Management Orientation and Annual Training Requirements (§74880, pp 68–75)

Thank you for exempting current hospice management personnel and internally promoted management personnel from the new-hire training requirements. However, the current text of the regulations does not allow hospices to accept credit for any training completed by a new senior staff member prior to the date of hire. While we support the comprehensiveness of the education requirements in the regulations, **we would recommend that the hospice be allowed to accept equivalent training from accredited training providers that was completed within one year prior to the date of hire.** Training and certification programs are time-intensive and financially burdensome; not allowing hospices to accept recently completed programs may create hardships for hospice agencies and disincentives to professionals to seek employment with a hospice. **In particular, if a new-hire hospice Medical Director has completed Hospice Medical Director certification within the past 2 years, this should be accepted as equivalent training.**

12. Plan of Correction implementation (§74904. Plan of Correction, p. 93)

We note there is no requirement included in the regulations that plans of correction be implemented or verified – the regulations only address the submission of the POC. **We recommend that the regulations include a requirement that each Plan of Correction have an expected date of implementation subject to verification by the Department and that any failure to meet the date of implementation (i.e., make the correction that is outlined in the plan) carry a penalty up to and including suspension of the hospice license.**

13. Additional comments/recommendations.

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.**

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 referral sources, cannot make informed choices about hospice care, for which 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.**

Volunteer and Bereavement programs. Finally, we urge CDPH to include a requirement that all licensed hospices demonstrate adherence to the federal Conditions of Participation with respect to volunteer hours and bereavement programs. 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.

Thank you!