

FINDING OF EMERGENCY

Emergency Regulations for Hospice Agencies (DPH-18-002E)

June 1, 2026

The Director of the California Department of Public Health (Department) finds that a factual emergency exists and that the proposed emergency regulations, as required by the Legislature, are necessary to address situations that call for immediate action to avoid serious harm to public peace, health, safety, and general welfare.

NOTICE AND INTRODUCTION

Notice is hereby given that the Department proposes to adopt the regulations described below. Government code section 11346.1(a)(2) requires that, at least five working days prior to submission of the proposed emergency action to the Office of Administrative Law, the adopting agency must provide a notice of the proposed emergency action to every person who has filed a request for notice of regulatory action with the agency. After submission of the proposed emergency to the Office of Administrative Law, the Office of Administrative Law shall allow interested persons five calendar days to submit comments on the proposed emergency regulations as set forth in Government Code section 11349.6.

FACTUAL EMERGENCY

In 2021, California enacted legislation imposing a moratorium on new hospice agency licenses pursuant to Senate Bill (SB) 664 and Health and Safety Code (HSC) section 1751.70. After California took this critical action to address fraud in the program, in March 2022, the California State Auditor (Auditor) published a report substantiating the significant concerns that the legislation aimed to address, including indicators of significant fraud and abuse by hospice agencies. The Audit Report concluded that immediate action needed to be taken to ensure the health and safety of hospice patients, as well as to address the growing indicators of fraud and abuse, particularly in Los Angeles County.¹

In 2022, the Legislature provided the Department with express authority to adopt emergency regulations to implement the Auditor's recommendations. (See Health and Safety Code (HSC) section 1753.1 as established by Assembly Bill (AB) 2673 (Irwin, Chapter 797, Statutes of 2022). Additionally, AB 2673 extended the earlier moratorium and mandated a deadline for promulgating emergency regulations. AB 177 (Chapter 999, Statutes of 2024) extended the deadline for the emergency regulations to January 1, 2026, and required the moratorium to end January 1, 2027, or one year after the date the emergency regulations are adopted, whichever is sooner.

Need for Emergency Regulations

¹ Cal. State Auditor, Rep. 2021-123, California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse (2022) (Audit Report).

Because these are new regulations with a very broad scope, the Department solicited and accepted written and verbal recommendations on the proposed hospice emergency regulations from the regulated community and other stakeholders on four separate occasions since 2022. Additionally, the proposed hospice emergency regulations were developed in coordination with the Department's consultants, surveyors, and subject matter experts. The Department has carefully considered the recommendations from all stakeholders and, where appropriate, incorporated the recommendations into the proposed regulations. Through careful consideration of the issues raised by the Auditor and all stakeholders, especially those representing legitimate hospice agencies, the Department is ready to promulgate these emergency regulations, which will be in place through the end of the hospice license moratorium while it prepares for a regular rulemaking to make these robust regulatory requirements permanent.

If emergency regulations are not adopted immediately, the Department will not have the robust regulatory requirements needed to protect the health and safety of hospice patients and to enhance its ongoing efforts to address the indicators of fraud and abuse identified in the Audit Report. Once implemented, the emergency regulations will provide the Department with even greater authority to deny initial licensure, investigate complaints, and/or revoke licenses and deny renewals when it determines a hospice operator is illegitimate or involved in overbilling.

The Department requires emergency regulations to establish more stringent criteria to evaluate new license applications and to discern legitimate hospice agencies that are hiring qualified personnel and providing care according to industry standards from the illegitimate operators engaged in fraudulent billing or substandard care. The documentation requirements in these emergency regulations will address the problem of identity theft of medical professionals to prevent the widespread abuse of falsely claiming a single administrator is serving dozens of phony hospice agencies. Implementing these emergency regulations is essential to protect patients and prevent fraud.

AUTHORITY AND REFERENCE

Authority: Health and Safety Code sections 1275, 1753, 1753.1, 131000, 131050, 131051, and 131200, Health and Safety Code.

Reference: Health and Safety Code Sections 20, 1201, 1253.2, 1253.3, 1266.5, 1746, 1746.50, 1746.52, 1747, 1747.1, 1747.3, 1747.5, 1748, 1749, 1750, 1751.100, 1751.5, 1751.75, 1752, 1752.1, 1753, 1753.1, 1754, 1755, 1756, and 18004.5, Health and Safety Code.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Purpose and Objective

The Department proposes to adopt emergency regulations to Title 22 of the California Code of Regulations (CCR) Division 5, Chapter 6.5 concerning hospice agencies as required by HSC section 1753.1. These proposed regulations will implement HSC

section 1753.1 to interpret and make specific industry standards and to put processes in place to improve patient care and combat Medicare and Medi-Cal fraud, by making it more difficult to establish fraudulent hospice agencies in California.

Background

HSC sections 1753 and 1753.1 grant the Department the authority to promulgate regulations for hospice agencies. At this time, the licensing requirements governing hospice agencies are the California Hospice Licensure Act of 1990, found in HSC Division 2 Chapter 8.5, and the California Hospice and Palliative Care Association (CHAPCA) Standards for Quality Hospice Care of 2003, as incorporated by reference in HSC section 1749(e). These current requirements are not sufficiently comprehensive to address all aspects of regulatory oversight, especially in the current climate of increasing sophisticated fraud schemes and, as noted above and in the Audit Report, given the prevalence and number of fraud indicators in Los Angeles County.²

Policy Statement Overview

Hospices provide palliative care to patients who are in the final stage of life, a time when patients are at their most vulnerable. Hospice fraud preys on these people, not just wasting public dollars but also robbing families of dignity, peace, and security. Protecting patients and safeguarding the integrity of the hospice industry is a top Department priority; and these regulations are intended to ensure that bad actors do not enter the hospice industry and to hold existing providers accountable. The regulations increase the Department's ongoing fraud and oversight protection efforts by establishing clear licensing standards for hospice patient care and business practices.

Patient Care Standards

Lack of patient care standards makes it difficult to ensure patients are receiving the level of care that they need. Measures such as adopting nurse-to-patient staffing ratios and limiting hospices to provide care only in specified geographic service areas will ensure patients regularly receive timely care from qualified staff.

Business Practice Standards

The current requirements are not comprehensive enough to address all aspects of hospice operations including expected business practice requirements. The new standards will help to ensure that hospice agency operators are reachable at their listed business phone numbers, email addresses, and mailing addresses for patients and families. Additionally, requiring detailed background information for owners and administrators allows the Department to evaluate whether these individuals have a history of conduct that could jeopardize patient safety or undermine the quality of care.

Problem Statement:

The Department has no regulations for hospice agencies. Emergency regulations under HSC section 1753.1 are necessary to enforce the California Hospice Licensure Act of

² Audit Report at page 28

1990, protect patient health and safety, and prevent and address hospice fraud in California.

In the California State Auditor Report 2021-123 on California Hospice Licensure and Oversight, the Audit Report identified several indicators of fraudulent practices, six of which the Legislature has expressly mandated that the Department address under emergency regulatory authority pursuant to HSC section 1753.1. These six practices are:

- Some hospice agencies employ management personnel responsible for more hospices than they can realistically oversee. One administrator managed 27 agencies. Others used names and personal information of individuals who were not actually employed.
- Multiple hospice agencies shared the same business address or operated in adjacent buildings without signage or capacity for operations.
- Agencies moved or sold their businesses without notifying the Department. Some obtained licensure and then immediately advertised their agencies for sale as “brand new, never billed” hospice solely for profit.
- Agencies seemingly hired management personnel with no experience or training in hospice care.
- Geographic service areas were often too large to reasonably provide timely and high-quality care.
- Lack of patient care standards to encourage accountability and to ensure sufficient nursing staff.

Objectives (Goals):

The broad objectives of this regulatory proposal are:

- Promulgate regulations to clarify standards for licensed hospices under HSC section 1753.1.
- Adopt application requirements that empower the Department to more comprehensively and effectively screen hospice licensure applicants.
- Prevent identity theft by requiring verification of hospice management staff employment.
- Ensure hospice services are needed in the proposed geographic areas to avoid oversaturation.
- Require qualified personnel to provide patient care.
- Continue combatting and preventing Medicare and Medi-Cal fraud in California.
- Protect hospice patient health and safety.
- Codify existing Department practices and industry standards for hospice agencies.
- Align requirements with newer federal rules and industry standards.

Benefits:

Anticipated benefits from adopting hospice agency emergency regulations as proposed are:

- Improve patient care and safety.
- Establish clear standards of care.
- Provide clarity and consistency to the regulated community.
- Enhance the Department’s surveying process.

EFFECT OF REGULATORY ACTION

This proposed action will add Title 22, California Code of Regulations, sections 74800, 74804, 74808, 74812, 74816, 74820, 74824, 74828, 74832, 74836, 74840, 74844, 74848, 74852, 74856, 74860, 74864, 74868, 74872, 74876, 74880, 74884, 74888, 74892, 74896, 74900, 74904, and 74908. These regulations comprise Division 5, Chapter 6.5, which includes 5 Articles, in Title 22 of the California Code of Regulations as follows:

ADOPT ARTICLE 1 “DEFINITIONS”

Adopt section 74800 “Definitions.” The Department is proposing to adopt a new Article 1 “Definitions.” These definitions are common industry terms for hospice agencies and are mentioned frequently throughout Chapter 6. The definitions added herein will provide overall clarity to the regulated community. Some definitions included here are from Title 42 of the Code of Federal Regulations (CFR) section 418.3, Health and Safety Code (HSC) section 1746, and the CHAPCA Standards. The Department is referencing these definitions in Title 22 for the convenience for the regulated community. Having all hospice definitions related to this chapter together in one central place will help avoid confusion because people will be able to quickly and easily reference them without needing to search through various websites and codes. The regulated community is going to need to work quickly to bring themselves into compliance with these new proposed regulations, therefore it is beneficial to have all the relevant information together to make the process as streamlined as possible. Having all definitions together also helps promote transparency by ensuring the Department is clear about the meaning of terms and expectations, which results in better compliance. In addition to the adoptions from the above sources, the Department proposes including the following:

Adopt subdivision (a)(1) to establish that “words will have their usual meaning unless the context or a definition clearly indicates a different meaning. Words used in the present tense include the future, words in the singular number include the plural number, and words in the plural number include the singular number. Must and will means mandatory. May means permissive. Should means suggested or recommended.” This “meaning of words” provision is included in many Title 22 facility types for clarity to the regulated community and for ease in enforcement. This regulation is proposed to be added to help to clarify the intent of regulations regardless of potential confusion for things like singular or plural term usage.

Adopt subdivision (a)(2) to establish that “Addendum” means new documentation added to a patient’s medical record by authorized hospice personnel after the time of original entry. This term is necessary because “addendum” is mentioned several times

in the regulations and this definition will help ensure patient medical records are well organized and properly maintained by the hospice. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(3) to establish that “Administrator” means an individual who is appointed in writing by the governing body of the hospice to organize and direct the services and functions of the hospice. This definition is needed to ensure the regulated community clearly understands what the administrator’s role is. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(4) to establish that “Administrator Designee” means an individual who is appointed in writing by the hospice Administrator and who assumes the same responsibilities and obligations of the Administrator when the Administrator is not available. This requirement is necessary to further clarify HSC section 1749(b)(1) which states that a hospice agency must have an administrator designee. This term is used frequently throughout this chapter and is necessary to clarify this individual’s roles and responsibilities, and how it differs from the roles and responsibilities of the primary hospice administrator. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(5) and (a)(5)(A) through (a)(5)(C) to establish that “Applicant” means any of the following: (A) An entity that is applying for a license to the Department to operate a hospice pursuant to Health and Safety Code section 1747; (B) A current licensee who is applying for a report of changes, or a license suspension reinstatement or an addition of a multiple location; (C) A prospective licensee who is applying for a change of ownership to assume control of the hospice from the current licensee. This term is necessary to capture all possible examples of a hospice applicant that is used throughout this chapter, especially in Article 2, and helps simplify the text for ease of reading. Additionally, the listed examples are consistent with the HS 200 Licensure & Certification form which must be used during the application process; this will help avoid unnecessary confusion for hospice applicants. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(6) to establish that “Application” means a required form provided by the Department which is required to be submitted to obtain or maintain a license. This definition is necessary to clarify for the regulated community that there is only one correct form to use when submitting a hospice application, which is provided by the Department. This is necessary to ensure agencies do not submit inaccurate or unacceptable “applications” which would delay the licensure process. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(7) to establish the term “Attending physician” to mean the physician chosen by the patient or the patient’s representative to be responsible for the medical treatment of the patient or a physician designated by the attending physician to act on the attending physician’s behalf while the attending physician is not available. This definition is necessary to establish that an attending physician is different from a hospice physician based on their roles and responsibilities on the hospice care team. This proposed definition is consistent with industry standards and will eliminate potential confusion in the regulated community by specifying how this physician is different from other physicians practicing in the hospice context. This individual is not employed by the hospice, but it is common industry practice for this individual to work in conjunction with hospice physicians to ensure the best quality care for patients. This definition is necessary for the Department to address the underlying emergency because it will prevent fraudulent billing by illegitimate hospice agencies that will blur the lines between defined roles and responsibilities to maximize revenue.

Adopt subdivision (a)(8) to establish the term “Authenticate” means proof of authorship or identity from an individual who is authorized by the hospice administrator to make entries into patient medical records, ensuring that the content of entries accurately reflects what the author intended. Examples of “authenticate” or “authentication” include, but are not limited to, an electronic signature, a unique code, a stamp, initials identifiable with a legend, or a written signature. This definition is necessary to promote accurate record-keeping and will help Department surveyors enforce the requirements of this chapter. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(9) and (a)(9)(A) through (a)(9)(C) to establish that the term “Authorized individuals” means: (A) Hospice personnel involved in the direct care of a patient; (B) Representatives of the Department; (C) Any individual or entity authorized to receive medical information, pursuant to Civil Code Division 1, Part 2.6, Civil Code 56.05(b), 56.10, and 56.20. This definition is necessary to clearly outline all examples the Department considers to be an “authorized individual.” Representatives of the Department are typically surveyors authorized to perform unannounced inspections to verify that the care being provided is in compliance with all regulatory requirements. Hospice personnel are authorized employees that need access to patient medical information to provide patient care. Lastly, medical requests can be made by and disclosed to authorized individuals as outlined under section 56.10(b) of Civil Code Division 1, Part 2.6. This proposed regulation is necessary to outline clear examples for the regulated community and to protect the health and safety of patients by ensuring that patient medical record information is only disclosed to authorized individuals consistent with The Confidentiality of Medical Information Act (CMIA). This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(10) and (a)(10)(A) through (a)(10)(C)(iii) to establish that the term “Beneficial ownership interest” means any of the following: (A) The possession of

an ownership interest by an entity, including a combination of direct and indirect ownership interests, totaling more than five percent but less than 50 percent in any hospice; (B) An ownership interest totaling more than five percent but less than 50 percent in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent of the value of the property or assets of the hospice; (C) The following individuals are deemed to have a beneficial ownership interest: (i) An officer or director of a licensed hospice or applicant for licensure of a hospice that is organized as a corporation; (ii) A partner in a licensed hospice or applicant for licensure of a hospice that is organized as a partnership; (iii) A member of a licensed hospice or applicant for licensure of a hospice that is organized as a limited liability company. This definition lists all possible examples of beneficial ownership interest that are referenced throughout Article 2. This definition was modeled after HSC section 1253.2(c) as well as the CMS definition of “person with an ownership or control interest” under Title 42 CFR section 455.101. This term is necessary to clarify who has ownership of a hospice agency for accurate recording and for accountability purposes, if necessary. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(11) to establish that the term “Bereavement services” has the meaning set forth in Health and Safety Code section 1746(a). Bereavement services are a vital aspect of hospice care that must be provided to the patient’s family. This proposed regulation is necessary to clarify that the term bereavement services in these regulations has the same meaning as current statute. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(12) to establish that the term “Business entity” means an entity who holds an active status with the California Secretary of State, including a domestic corporation, foreign corporation, limited liability company, foreign limited liability company, limited partnership, or foreign limited partnership. This term is necessary to differentiate between a “business entity” and just an “entity” found under subdivision (a)(21). This definition is also necessary for full transparency to prospective applicants and current licensees regarding the different organization types that the Department would consider to be a business entity when completing application forms described in Article 2. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(13) to establish that the term “Business hours” means the hours during the day in which the hospice agency office is open and available to the public. Business hours must be scheduled on a consistent basis in terms of hours and days of operation in accordance with the operational needs of the hospice. This definition is necessary to provide clarity and context for the operational hours of the hospice agency office. This is necessary because while hospice/nursing services are provided to patients 24/7 as needed, the agency’s public office is not open and operating 24/7.

Hospice agencies today are likely to use a calling service to triage patient needs and get them after-hours assistance; therefore, it is necessary to clarify this difference in the regulations. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(14) to establish that the term “Comprehensive assessment” has the meaning set forth in Title 42 of the Code of Federal Regulations section 418.3. The development and implementation of a patient’s comprehensive assessment is a vital aspect of hospice care. This proposed regulation is necessary to clarify to the regulated community that the term comprehensive assessments in these regulations has the same meaning as current federal hospice regulations. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(15) to establish that the term “Day” means a calendar day, unless otherwise specified in this chapter. A calendar day includes weekends and holidays. This definition is necessary for clarity and ease of reading. The hospice application process and the plan of care requirements for patients have strict timelines that must be adhered to, and needing to repeatedly identify whether each one follows a business day or a calendar day would be unnecessary. Most requirements follow a calendar day schedule which is why it was chosen as the default. This definition is therefore necessary to set clear expectations to avoid delays and errors in the application process and also to protect the health and safety of patients. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(16) to establish that the term “Department” means the California Department of Public Health. This definition is necessary to clarify for the regulated community that while there are many different CA Departments and oversight agencies, the California Department of Public Health (CDPH) is the main organization responsible for licensing and overseeing hospice agencies in the state and is therefore the primary Department referenced throughout the regulations. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(17) to establish that the term “Director of Patient Care Services” means a licensed registered nurse who is appointed in writing by the governing body of the hospice to be responsible for clinical direction and supervision of patient care services. This definition is necessary to make it clear for the regulated community what the qualifications and responsibilities are for this role. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(18) to establish that the term “Director of Patient Care Services Designee” means a licensed registered nurse who is appointed in writing by the hospice

Administrator and who assumes the same responsibilities and obligations of the Director of Patient Care Services when the Director of Patient Care Services is not available. This definition is necessary for the same reasons identified in subdivision (a)(17), and how the roles and responsibilities of this individual differ from the primary Director of Patient Care Services. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(19) and (a)(19)(A) through (a)(1)(C) to establish that the term “Double billing” or “excessive billing” means any of the following: (A) Billing Medicare or Medi-Cal multiple times for the same service or item; (B) Billing multiple government programs for the same service or item; (C) Billing the same service or item to a government program and a private healthcare insurer. This definition is necessary to differentiate between regular and double (or “excessive”) billing, and to note specific examples of double billing. The Audit Report identified double billing as a concern for fraudulent activity within the industry. It is therefore necessary to clarify this term because double billing is grounds for denial of a hospice licensure application if it is found that the hospice agency employs any management personnel with a history of double billing. This definition is necessary for the Department to be able to implement meaningful oversight to prevent future fraudulent activity. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(20) to establish that the term “Electronic health record” means a patient’s health record stored in an electronic health record system and maintained by the hospice which can be shared with other health care providers involved in the patient’s care. This definition is necessary to clarify the difference between a hard copy record and an electronic health record. An electronic health record is an electronic version of a patient’s health record stored in an electronic health record system and maintained by the hospice. Many hospices now use electronic health record systems to keep track of patient’s medical records and have shifted away from traditional hard copy records. This definition is necessary to reflect current industry practice. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(21) and (a)(21)(A) through (a)(21)(J) to establish that the term “Entity” means any of the following: (A) Individual; (B) Corporation; (C) Partnership; (D) Limited liability company; (E) Firm; (F) Association; (G) Organization; (H) Business trust; (I) Public agency; and (J) Company. This definition is necessary to establish the different types of business organizations that the Department considers an entity. This term is necessary because it serves as an umbrella that captures all types of applicants. It is much easier to just use the word “entity” throughout the text rather than listing all the different types of business organizations each time. It avoids repetition and helps simplify the regulatory text. Also, this term is needed to avoid confusion between the term “business entity” mentioned above under subdivision (b)(12). This definition is necessary to establish a robust regulatory framework with consistently applied

terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(22) to establish that the term “Established place of business” means unshared office space located in a commercial building. Hospice agencies do not operate in a patient care setting, therefore there must be a physical office location for the public and Department surveyors to be able to conduct business or conduct surveys. This office location is where the administrative work takes place and where highly sensitive hard-copy patient medical records would be stored, which is why an unshared space is necessary. The Department has received past requests from applicants to set up a hospice office agency in their personal residence, which is unprofessional and likely to be unsecure for the type of work that is taking place. This term is necessary to protect the health and safety of patients including their personal medical information. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(23) to establish that the term “Geographic service area” means the county or counties approved by the Department in which the parent hospice, including all multiple locations if any, is licensed to provide hospice services to patients. This definition is necessary to clarify the terms “geographic service area,” “geographic area,” and “service area” referenced throughout HSC section 1749(f). This is necessary for the regulated community to understand that these terms all share the same meaning and are being used interchangeably. This adoption is also necessary to provide context and clarity throughout this chapter, especially section 74820 (Geographic Service Area) in Article 2. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(24) to establish that the term “Hospice” means an individual hospice, including any approved multiple locations, licensed by the Department and has the meaning set forth in Health and Safety Code section 1746(d). This is necessary to clarify that the term “hospice” used throughout the text means the singular agency named on the license, which includes any multiple locations that operate under that same license. This is similar in nature to the definition of “parent hospice” or “parent agency” found under subdivision (a)(44). This term is used very frequently throughout this chapter and is necessary to provide clarity to the regulated community. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(25) and (a)(25)(A) through (a)(25)(F) to establish that the term “Hospice management personnel” or “management personnel” means the key positions responsible for overseeing the hospice, including, but not limited to, the: (A) Administrator; (B) Administrator Designee; (C) Director of Patient Care Services; (D) Director of Patient Care Services Designee; (E) Medical Director; and (F) Medical Director Designee. This definition is necessary to clarify HSC 1753.1(d) which requires hospice agency management personnel to meet minimum standards of training and

experience. Stakeholders have also requested clarification of this term and are in agreement with the individuals included in this definition. This term is used frequently throughout this chapter and is necessary to clarify for the regulated community, for personnel, and for patients and their families who are responsible for managing the hospice agency. This term is also necessary for accountability purposes. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(26) to establish that the term “Hospice physician” or “physician” means an individual licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California who is employed or contracted by a hospice. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

This definition is similar to the one found in the CHAPCA Standards, with the following adjustments:

- The Department removed “who serves as a member of the hospice interdisciplinary team” because the definition section is not the appropriate place to include that requirement. Article 1 definitions should not discuss the roles, responsibilities, experience requirements, etc. of hospice personnel; it should only include and clarify *what the term is*. The Department does however agree with CHAPCA that a physician must be part of a patient’s interdisciplinary team which is clearly required under the “interdisciplinary team” definition found in subdivision (31)(A).
- The Department added the additional clarification that a hospice physician must be “employed or contracted by the hospice.” This language is consistent with the requirements for the hospice Medical Director and Medical Director Designee physician positions as seen under section 74856 (Medical Director) subdivision (d).

Adopt subdivision (a)(27) to establish that the term “Hospice services” mean types of services provided by a hospice as set forth in Health and Safety Code section 1746 and Title 42 of the Code of Federal Regulations section 418.64. This is necessary to clarify that “hospice services” has the same meaning as the term is used in current federal regulations and current statute as identified in the text. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(28) and (a)(28)(A) through (a)(28)(L) to establish that the term “Immediate family member” means any of the following: (A) Spouse or a registered domestic partner or cohabitant; (B) Natural or adoptive parent; (C) Grandparent or great grandparent; (D) Child or grandchild; (E) Sibling or half-sibling; (F) Stepparent, stepchild, stepsibling, or step-grandchild; (G) Mother-in-law or father-in-law.

(H) Brother-in-law or sister-in-law; (I) Daughter-in-law or son-in-law; (J) Aunt or uncle; (K) Niece or nephew; and (L) First cousin. This is necessary to clarify all individuals the Department would consider to be an immediate family member. This term is used in section 74812 (Content of Application) and is necessary for applicants to understand how to properly complete a hospice application, specifically section 74812(c)(22)(I) which requires additional information for individuals who “have authority or responsibility for the operation of the agency and if they are related to one another as an immediate family member.” The Department has determined these individuals have a close enough relationship to one another that should be documented and monitored for potential nepotism. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(29) to establish that the term “Immediate jeopardy” means a situation in which the licensee’s noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. This definition mirrors the one found under HSC section 1280.3(h) and is necessary to maintain consistency among facility types. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(30) to establish that the term “Initial assessment” has the meaning set forth in Title 42 of the Code of Federal Regulations section 418.3. This proposed definition is necessary to clarify that “initial assessments” has the same meaning as the term is used in current federal hospice regulations. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(31) and (a)(31)(A) through (a)(31)(I) to establish that the term “Interdisciplinary team” means the hospice care team that includes, but is not limited to: (A) A physician and surgeon; (B) A registered nurse; (C) A social worker, marriage and family therapist, or a mental health counselor; (D) A volunteer; (E) A spiritual counselor; (F) The patient; (G) The patient’s family, if they so desire; (H) The patient’s representative, if applicable, if they so desire; and (I) The patient’s caregiver, if applicable, if they so desire. This definition includes all the same individuals from CHAPCA’s definition, with the following additions:

- A marriage and family therapist or a mental health counselor, along with a social worker, was added to align with the updated CMS federal regulations under Title 42 CFR section 418.56(a)(1)(iii).
- It is reasonable and appropriate to add the patient’s representative and/or caregiver, if they choose to participate. These individuals will be assisting the patient day-to-day and have a close personal relationship with the patient, making them a valuable asset to the care team.

This definition is necessary to clarify who must be included in a patient's interdisciplinary team. This term is used many times throughout this chapter, especially Article 4, and is necessary to provide context and clarity to the regulated community and hospice patients/families. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(32) to establish that the term "Involuntary suspension" means an enforcement action initiated by the Department to suspend a licensee's privilege to operate a hospice. This is necessary to distinguish and help clarify the difference between a voluntary versus an involuntary suspension. This definition is necessary to avoid confusion between sections 74840 (Voluntary Cancellation of License) and 74844 (Involuntary License Suspension, Revocation, and Reinstatement). It also matches the Centralized Application Branch's intent for instances when they need to impose an involuntary suspension. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(33) to establish that the term "License" means the document issued by the Department permitting the operation of a hospice. This document constitutes the authority to accept patients and to perform the services as specified on the hospice license. This term is used frequently throughout this chapter, especially Article 2, and aligns with the definitions found in the CHAPCA Standards as well as Home Health Agency (HHA) regulations under Title 22 CCR section 74627. The language "basic" and "within the scope of these regulations" were removed for simplification and ease of reading. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(34) to establish that the term "Licensee" means an applicant to whom a license has been issued by the Department to operate a hospice in the State of California. This definition is necessary to help distinguish the difference between licensees who currently hold licensure, and any applicants which are individuals seeking licensure but have not yet obtained it. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(35) to establish that the term "Licensed vocational nurse" means an individual who is currently licensed as a licensed vocational nurse by the State of California Board of Vocational Nursing and Psychiatric Technicians. This definition matches the one found in the CHAPCA Standards but adds a little extra clarification that the individual must be "currently" licensed. This adds a necessary extra layer of protection for patients by ensuring only a nurse holding a valid license may provide care which is standard industry practice. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(36) to establish that the term “Medical direction” has the meaning set forth in Health and Safety Code section 1746(h). This definition is necessary to clarify that “medical direction” has the same meaning as the term is used in current statute. This is necessary to ensure that the medical professionals required to provide such services are clear about the expectations they must meet to be compliant with the requirements of this chapter. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(37) to establish that the term “Medical Director” means an individual who is currently licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California who is appointed in writing by the governing body of the hospice to be responsible for the overall medical direction of the hospice. This definition is necessary to make it clear for the regulated community what the qualifications and responsibilities are for this role. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(38) to establish that the term “Medical Director Designee” means an individual who is currently licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California who is appointed in writing by the hospice Administrator and who assumes the same responsibilities and obligations of the Medical Director when the Medical Director is not available. This definition is necessary to make it clear for the regulated community the qualifications and responsibilities for this role and how the Medical Director Designee’s role and responsibilities differ from those of the primary Medical Director. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(39) to establish that the term “Medical record” or “patient medical record” means documentation of all clinical services provided to a patient in the hospice. A medical record may be a hard copy document or electronic record, including a hard or electronic copy of original content. This is necessary to establish the difference between a medical record and an electronic health record (or just “health record”) as seen in subdivision (a)(20). A medical record is typically limited to a singular practice, whereas a health record can be shared and used across multiple healthcare settings. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(40) to establish that the term “Multiple location” has the meaning set forth in Health and Safety Code section 1746(i). This definition is necessary to clarify that “multiple location” has the same meaning as the term is used in current statute. This is necessary to avoid confusion during the application process and for transparency when calculating

licensing fees. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(41), (a)(41)(A), and (a)(41)(B) to establish that the term “Ownership interest” means the possession of equity in capital, stock, principal property, assets, or profits of a licensed hospice. An ownership interest may be either direct or indirect; (A) A direct ownership interest is an ownership interest in the licensed hospice, applicant for licensure, or licensee of a hospice; (B) An indirect ownership interest is an ownership interest in an entity that itself has an ownership interest in a licensed hospice, applicant for licensure, or licensee of a hospice. This is necessary for reasons similar to subdivision (a)(10) above. This term is necessary to provide clarity to hospice applicants and ensure they are able to complete the requirements of section 74812 (Content of Application) correctly. It also matches the CMS definitions for “ownership interest” and “indirect ownership interest” under Title 42 CFR 455.101 and is consistent with the definition applied to other facility types regulated by the Department for example HSC section 1253.2 applicable to skilled nursing facilities. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(42) to establish that the term “Palliative care” has the meaning set forth in Health and Safety Code section 1746(j). This definition is necessary to clarify that “palliative care” has the same meaning as the term is used in current statute. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(43) to establish that the term “Parent hospice” or “parent agency” has the meaning set forth in Health and Safety Code section 1746(k). This definition is necessary to clarify that “parent hospice” or “parent agency” has the same meaning as the term is used in current statute. This is necessary to avoid confusion during the application process and for transparency when calculating licensing fees. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(44) to establish that the term “Patient” means an individual receiving palliative treatment for management of a terminal illness and its related conditions. This definition is necessary to remain aligned with the CHAPCA Standards. This common industry term is used frequently throughout the hospice regulations and must be included for the regulations to have a comprehensive and complete list of definitions. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(45) and (a)(45)(A) through (a)(45)(C) to establish that the term “Patient’s representative” or “representative” has the meaning set forth in Health and Safety Code section 1751.100(b)(1). For the purposes of this chapter, “a person

delegated by the patient” includes, but is not limited to: (A) A guardian; (B) A conservator; and (C) A patient selected representative who participates in making decisions related to the patient’s care or well-being, including but not limited to, a family member or advocate for the patient. This definition is necessary to clarify HSC section 1751.100(b)(1) by identifying a few acceptable examples of “a person delegated by the patient.” This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(46) to establish that the term "Personnel" means individuals employed, contracted, or compensated by the hospice. Volunteers are excluded from the definition of personnel, even though they are frequently included on a hospice interdisciplinary team, to clarify to the regulated community when the Department is regulating the conduct of individuals paid by the hospice agency. This term is used frequently throughout this chapter and is necessary to clearly differentiate between the types of individuals working at the hospice such as paid or unpaid individuals. For example. Hospices are required to provide volunteer services however volunteers are not considered personnel because they are not financially compensated by the hospice. This proposed regulation is necessary to clarify for the regulated community who within the hospice is considered personnel. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(47) to establish that the term “Plan of care” has the meaning set forth in Health and Safety Code section 1746(l). The development and implementation of a patient’s plan of care is a vital aspect of hospice care. This proposed regulation is necessary to clarify that “plan of care” has the same meaning as the term is used in current statute. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(48) to establish that the term “Primary caregiver” or “caregiver” means a person not employed by the hospice but designated by the patient or patient’s representative as responsible for ensuring the day-to-day needs of the patient are met. This definition is necessary to remain aligned with the CHAPCA Standards. A hospice patient’s caregiver provides critical physical and emotional support, so it is beneficial to include this definition for accountability and proper enforcement. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(49) to establish that the term “Registered nurse” means an individual licensed as a registered nurse in the State of California by the Board of Registered Nursing. This definition is necessary to remain aligned with the CHAPCA Standards. A registered nurse is a pivotal part of a hospice patient’s care so it is necessary to make it clear that this individual must meet all California licensing requirements. This definition is necessary to establish a robust regulatory framework

with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(50) to establish that the term “Representative of the Department” means a representative appointed or contracted by the Department to inspect a hospice. The Department has authority to inspect hospice agencies to verify compliance with all regulatory requirements, therefore it is necessary to say who these individuals are and make it clear that these individuals must be approved by the Department. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(51) to establish that the term “Residence” means wherever the patient lives, including temporary or permanent stays in health or community care facilities. This definition is necessary to remain aligned with the CHAPCA Standards. Hospice care is typically provided in a patient’s home. This definition is necessary to provide clarity to the regulated community and for meaningful enforcement by the Department. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(52) and (a)(52)(A) through (a)(52)(Y) to establish that the term “Rural area” means any county within the State of California that has a population of less than 150,000 people, which includes all the following counties as of January 1, 2025: (A) Alpine County; (B) Amador County; (C) Calaveras County; (D) Colusa County; (E) Del Norte County; (F) Glenn County; (G) Humboldt County; (H) Inyo County; (I) Lake County; (J) Lassen County; (K) Mariposa County; (L) Mendocino County; (M) Modoc County; (N) Mono County; (O) Napa County; (P) Nevada County; (Q) Plumas County; (R) San Benito County; (S) Sierra County; (T) Siskiyou County; (U) Sutter County; (V) Tehama County; (W) Trinity County; (X) Tuolumne County; and (Y) Yuba County. This definition is necessary to fully effectuate HSC section 1753.1(c). The Audit Report identified a concern where hospice management personnel were supposedly working for an unreasonably large number of hospice agencies. As a result, the Department was statutorily obligated to establish a limit for how many hospice agencies hospice management personnel should be able to oversee concurrently and it was determined that only one agency was appropriate, with an exception for rural areas.

This definition was modeled after GACH regulations under Title 22 CCR section 70059.1, which classifies a rural area as “any area which is located more than 30 miles or 30 minutes driving distance from the city hall for any metropolitan area with a population of 150,000 or more.” The Department did not adopt the 30 miles or 30-minute driving distance standard because it appeared to be too lenient in practice, especially for most southern California cities that experience dense traffic conditions. The Department, however, did use the 150,000-population marker as an indication of a rural area. The Department then specifically listed all counties within California that meet this requirement using the most currently available census data. Identifying these

counties directly into the definition was the simplest approach and provides the most transparency to the regulated community. This term is necessary to easily identify which counties within California are deemed “rural areas” and qualify for the exemption to the hospice management personnel agency limitations under sections 74852(g), 74856(g), and 84876(g). This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(53) to establish that the term “Significant business transaction” means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of \$25,000 or five percent of an applicant’s or provider’s total operating expenses. This definition is necessary to clarify to the regulated community when completing a hospice application. This term is used in section 74812 (Content of Application) which closely mirrors the HS 200 Licensure & Certification Application. For example, if a current or proposed hospice agency want to apply for Medi-Cal certification, the applicant must complete “Attachment F-1: Subcontractor Information and Significant Business Transactions.” This definition is modeled after the federal definition in Title 42 section 455.101 and is necessary to help eliminate any confusion for applicants when completing the application process. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivisions (a)(54), (a)(54(A), and (a)(54)(B) to establish that the term “Subcontractor” means either of the following: (A) An entity to which the applicant has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients; (B) An entity with whom the applicant has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program. This definition is necessary to provide clarity to the regulated community when completing a hospice application. This term is used in section 74812 (Content of Application) which closely mirrors the HS 200 Licensure & Certification Application. For example, if a current or proposed hospice agency want to apply for Medi-Cal certification, the applicant must complete “Attachment F-1: Subcontractor Information and Significant Business Transactions.” This definition matches the federal definition in Title 42 section 455.101 and is necessary to help eliminate any confusion for applicants when completing the application process. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(55) to establish that the term “Terminal illness” or “terminal disease” has the meaning set forth in Health and Safety Code section 1746(p). This definition is necessary to make clear that the regulated community must follow the definition of “terminal illness” or “terminal disease” as found under current statute. This is necessary to avoid confusion for any hospice medical professionals that participate in

the CMS program which follows a prognosis of 6 months instead of 12 months under HSC. The Department must adhere to and enforce any current California statute and therefore mirrored the HSC definition into these regulations. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(56) to establish that the term “Unmet need” means there is a population of terminally ill patients in a county who are likely eligible for hospice care for which the existing hospices in the county are not able to provide care. This definition is necessary to clarify the statutory requirement under HSC section 1749(f)(1) which states that an applicant for hospice licensure must demonstrate and provide evidence of an “unmet need for hospice services” in the geographic service area (GSA) that the hospice agency wishes to serve. Without a proper definition this term is extremely unclear and ambiguous and creates a lot of uncertainty for prospective hospice applicants. This definition is necessary to streamline the hospice application process and to set clear guidelines throughout the text, most importantly in section 74820 (Geographic Service Area). For further justification, please refer to the ISOR section 74820. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(57) to establish that the term “Upcoding” means a form of medical billing fraud in which a healthcare provider submits a code for diagnosis, an item, or service that is reimbursable at a higher rate than the item or service that was actually rendered or condition that was diagnosed. This definition is necessary to provide more detail and clarification on the types of fraudulent billing activities that may cause a denial of an application, as seen under section 74832(b)(1)(B). This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

Adopt subdivision (a)(58) to establish that the term “Wholly owned supplier” means a supplier whose total ownership interest is held by the applicant or another entity with an ownership interest or control interest, or both, in the applicant. This definition is necessary to provide clarity to the regulated community when completing a hospice application. This term is used in section 74812 (Content of Application) which closely mirrors the HS 200 Licensure & Certification Application. For example, if a current or proposed hospice agency want to apply for Medi-Cal certification, the applicant must complete “Attachment F-1: Subcontractor Information and Significant Business Transactions.” This definition was modeled after the federal definition in Title 42 section 455.101 and is necessary to help eliminate any confusion for applicants when completing the application process. This definition is necessary to establish a robust regulatory framework with consistently applied terminology that can be clearly understood by hospice agencies and patients.

ADOPT ARTICLE 2 “LICENSE”

The Department ensures standardization and consistency in state licensing and federal certification through the application process. The Department’s Health Facility Evaluation Nurses, physicians, and other medical consultants regularly survey facilities, including hospice agencies, and investigate complaints to assess compliance with state statutes and regulations. This article will cover the regulatory framework established by the Department to enforce standards for hospice agencies, as well as requirements they must meet to obtain and maintain licensure. A few key aspects this article will discuss are general expectations for hospice inspections, the different application processes, and the disciplinary sanctions imposed by the Department. The requirements found in Article 2 are common for all Title 22 facility types and are necessary to align with existing practice.

Adopt section 74804 “General Licensing Requirements.”

Adopt subdivision (a) to prohibit applicants from operating a hospice until they are properly licensed by the Department. The mission of the Center for Health Care Quality (CHCQ) within the Department is to protect the quality and safety of health care for all Californians by providing regulatory oversight of health care facilities, including hospice agencies. One of the ways this mission is achieved is by carefully reviewing, analyzing and verifying all applications for hospice licensure submitted to the Department. Once approved, then a license is granted to the applicant. HSC section 1747(a) states that no one in California will establish or operate a hospice without first obtaining a license. This prohibitive language is necessary to adopt because it makes the current statute more specific by clarifying what “operating” consists of, which is admitting patients and advertising or initiating services. This requirement is necessary to address several misleading business practices used by illegitimate hospice agency operators. This section specifies the criteria the Department evaluates and the requirements hospices must meet to comply with these regulations.

Adopt subdivision (b) to establish that the hospice must maintain accurate and current license records accessible to the Department and the public. The subsequent subdivisions clarify how the licensee must retain and display its license records for the public and for the Department’s surveyor teams.

Adopt subdivision (b)(1) to establish that a licensee must retain a current copy of the license issued by the Department. The Audit Report found that several operators failed to retain a current copy of their license, which made verification impossible. This requirement is necessary because the licensee should always have the most updated copy of the license on file for inspection by the Department or the public. If the licensee requests a report of change, such as change of name or location, and if the change is approved by the Department, the licensee receives a new copy of the license with displayed information reflecting that change (e.g. a name or the address of the licensee/hospice). The licensee must retain the most current copy of the license issued by the Department. This ensures clarity during inspections or when verifying licensure status.

Adopt subdivision (b)(2) to establish that a hospice must post an unaltered copy of the license in a conspicuous location within the hospice's established place of business. The practice of posting an authentic license in a visible, commercial location promotes transparency and trust to the public. It also provides patients and their representatives with confidence and a means to easily validate the status of the hospice's licensure. The term "established place of business" is defined in 74800(a)(22). The Audit Report found that several operators failed to conspicuously post their licenses for inspection, and this requirement is necessary to address that problem.

Adopt subdivision (c) to establish that licensed health facilities, as defined in Health and Safety Code section 1250, or home health agencies, as defined in Health and Safety Code section 1727, must obtain a separate license to operate a hospice agency pursuant to this chapter. This requirement is necessary to prevent the improper offering of hospice services without meeting the necessary regulatory requirements. For example, consider a corporation, ABC Inc., which owns a general acute care hospital called ABC Medical. If ABC Inc. wishes to provide hospice services, it cannot do so under the existing ABC Medical license. Instead, ABC Inc must submit a separate, initial application specifically for hospice licensure. This ensures that the hospice operation of the ABC Inc. undergoes a dedicated application process and inspection to confirm its compliance with the specific requirements for hospice care outlined in this chapter. By requiring a separate hospice license, ABC Inc. will manage two distinct facilities (licenses), ABC Medical and ABC Hospice, each individually reviewed and approved by the Department. The Department also tracks and monitors facility information separately based on the different types of facilities the licensee is licensed for. This subdivision further clarifies Health and Safety Code section 1747.

Adopt section 74808 "Inspection."

All healthcare facilities governed by Title 22 CCR have adopted regulations addressing inspection standards to be enforced by Department surveyors. Hospice regulations must include a dedicated inspection section to align with Title 22 CCR standards. This proposed section provides the industry with detailed guidelines on what to expect when the Department performs an inspection.

Adopt subdivision (a) to establish that a hospice is subject to inspection before and after licensure to ensure compliance with the Health and Safety Code. Health and Safety Code section 1752(a) authorizes periodic inspections to verify compliance with this chapter and its regulations. This is necessary to set a ground rule for hospice agency inspections. HSC section 1752(a) states, "a licensed hospice may periodically be inspected" and "the inspection is for the purpose of ensuring that this chapter and the rules and regulations adopted under this chapter are being followed." The Department further specifies the statute by stating that hospices can also be inspected before the license is issued to the applicant and outlining what set of regulations hospices must comply with. Furthermore, the Audit Report also recommended that the Department should increase its inspection activity to include initial licensing site visits and

probational site visits.³ This adoption is necessary to reflect the current Department practice and clarify the statutory requirement.

Adopt subdivision (b) to establish that inspections of a hospice by the Department may be unannounced. This is necessary to put the regulated community on notice to avoid any objections based on the perception of unfair surprise. Performing unannounced inspections allows surveyors to observe the site under normal circumstances, capturing a realistic snapshot of the day-to-day activities and operation of the hospice. The absence of notice from the Department also compels the hospice to promote a culture of responsibility and accountability, proactively mitigating non-compliance activities on a daily basis, which will further ensure the health and safety of patients. Furthermore, hospice surveys should be unannounced based on the federal survey guideline from the CMS State Operations Manual.⁴ This requirement is necessary because unannounced inspections ensure accurate observation of routine operations and align with CMS federal guidelines.

Adopt subdivision (c) to establish that inspections may occur at any time, including outside business hours, to reflect the 24/7 nature of hospice services, which clarifies the requirements of HSC section 1752(b). The statute states an inspection can be done “at any reasonable time,” however this language is too vague and unenforceable. This regulation will clarify that “anytime” means the Department has authority to perform an inspection 24/7 because hospice services are technically provided 24/7 including business hours and on-call hours. This is necessary to put the regulated community on notice to avoid any objections based on the perception of unfair surprise.

Adopt subdivision (d) to establish that the hospice must provide the Department access to the hospice upon presentation of valid identification from any representative of the Department assigned to conduct the inspection. A hospice that fails to provide access during the inspection is subject to denial, suspension, or revocation of its hospice license. This requirement is necessary to put the regulated community on notice of the potential consequences if a verified Department surveyor is denied access to the hospice and is unable to perform an inspection. Inspections are an existing practice for all Department facility types, and refusing to cooperate can be taken as attempting to hide noncompliance which can lead to enforcement actions being imposed on the licensee. This regulation is necessary to ensure that Department surveyors can perform their duties without unnecessary delays or interruption as a surveyor’s time and schedule is very limited. Adopting this regulation also aligns with

³ Audit Report at pg. 51

⁴ Centers for Medicare and Medicaid Services. “*State Operations Manual, Appendix M – Guidance to Surveyors: Hospice, (Rev. 222; Issued: 06-07-24). Types of Hospice Surveys.*” Page 8. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

the federal procedures for Medicare certification surveys outlined in the CMS State Operations Manual.⁵

Upon arrival, the surveyor(s) must present identification. If the hospice denies entrance to the facility or otherwise tries to limit required survey activities, explain that this may be grounds for OIG to exclude the hospice from participation in Medicare. (See 42 CFR § 1001.1301.) Denying entrance to the facility (42 CFR § 489.53(a)(18)) and refusing to permit copying of any records or information during the survey (42 CFR §(a)(13)), may also be grounds for CMS to terminate the hospice's provider agreement.

This is necessary to put the regulated community on notice to avoid any objections based on the perception of unfair surprise. This requirement is necessary to harmonize the state inspection practice with federal standards.

Adopt subdivisions (e) to establish that the hospice must make available all requested written and electronic documents, forms, records, or files of the licensee for the Department to inspect, photocopy, or scan. This requirement is necessary because reviewing written records and documents is a standard enforcement practice that is necessary to verify hospice compliance with applicable laws and regulations. This regulation supports the Department's authority to perform necessary duties which includes retrieving information for analysis and evaluation.

The Department further proposes to **adopt subdivisions (e)(1) through (e)(10)** outlining the types of documents and records that are subject for review.

Subdivision (e)(1): Medical records are a standard part of providing care to patients, and reviewing records is a common inspection practice to verify all services and activity.

Subdivision (e)(2): The hospice Audit Report indicates significant fraudulent billing activities for Medicare and Medi-Cal in the industry. Reviewing billing records helps to prevent those fraudulent billing activities.

Subdivision (e)(3): To ensure the hospice is following standards of qualification. Credentialing ensures that any physicians, nurses, and allied health professionals working in the hospice have the proper license and documentation to provide care and services. Privileging requires these

⁵ Centers for Medicare and Medicaid Services. "State Operations Manual, Appendix M – Guidance to Surveyors: Hospice, (Rev. 222; Issued: 06-07-24). General Procedures – Arrival." Page 14. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

health practitioners to prove they are capable of the specific skills they intend to perform.⁶

Subdivision (e)(4) has similar reasons with (e)(3). To confirm that personnel are competent to perform their duties, and if they are properly licensed.

Subdivision (e)(5): To ensure employees are receiving correct wages and compensation.

Subdivision (e)(6): To ensure hospice personnel's skills and knowledge are up to date, and that they have taken the required trainings sessions/courses.

Subdivision (e)(7): To ensure employees have policies and procedures (P&Ps) in place, and to validate whether employees are following the established P&Ps.

Subdivision (e)(8): To learn what happened during the incident, and what precautionary measures have been considered to prevent incidents from happening again.

Subdivision (e)(9): To ensure manufacturer instructions are followed when using the equipment.

Subdivision (e)(10): To ensure contracts are legally binding and to verify whether the terms and conditions outlined in a contract are being upheld.

These additional requirements are necessary to put the regulated community on notice to avoid any objections based on the perception of unfair surprise.

Adopt subdivision (f) to establish that the hospice must provide the Department with all necessary passwords and authorizations and enable systems required for the Department to access electronic information. This requirement is necessary to support the minimum amount of transparency during information retrieval during an inspection. Generally, requesting passwords is not necessary during a routine inspection for licensure because most hospices are cooperative, and the escorts/navigators will give access and authorization to their electronic information system. However, during a complaint investigation, requesting passwords may become necessary to ensure the Department receives unrestricted access to all critical electronic information. This will help ensure the Department is able to perform a thorough investigation without worrying that the

⁶ Sarah Jones, MedTrainer. "An Introduction: The Difference Between Credentialing and Privileging." Last accessed on 11/22/2024. <https://medtrainer.com/blog/an-introduction-the-difference-between-credentialing-and-privileging/>

hospice might be withholding important information. This regulation is necessary to ensure the Department surveyors acquire all necessary information to perform their duties and properly complete a hospice inspection.

Adopt subdivisions (g), (g)(1) and (g)(2) to establish that the hospice must allow the Department to: (1) Interview patients, patient representatives, the hospice applicant or licensee, the governing body, the hospice owners, officials, hospice management personnel, and other personnel; and (2) Seek patient consent to conduct on-site observation of patient care where the care is provided. This requirement is necessary to establish that the Department may pursue standard investigation techniques when evaluating a licensee. Interviewing and observing patients on-site are core components of a Department inspection. Interviewing and observing patients (or patient representatives) help the surveyor to understand the patient's condition, reason for admission, quality of care, and the patient's overall clarity and understanding of their plan of care and the services being provided to them. Interviewing hospice personnel helps the surveyor assess the knowledge of patient's needs, clinical proficiency of care providers, plan of care, and progress towards patient goals. The language about patient consent clarifies that surveyors respect patient's privacy and will maintain patient confidentiality at all times. Patients must also confirm if they are comfortable with the surveyor's observation and/or interviewing. This regulation provides clarity to these two core inspection activities. These additional requirements are necessary to put the regulated community on notice to avoid any objections based on the perception of unfair surprise.

Adopt section 74812 "Content of Application."

This proposed section specifies the application content required for obtaining a hospice license. The Department must review and approve the complete application packet before issuing a hospice license. The listed requirements correspond to those in the Department's official application forms and related documents. The Department uses the HS 200 application series (HS200, HS215, HS309, HS328) to process hospice applications. Listing requirements in regulatory language ensures transparency and allows future amendments without invalidating existing provisions. This approach maintains validity of existing requirements while enabling adoption of new provisions as needed.

These provisions are necessary to align Title 22 regulations with current Department practices. Several requirements support Department survey activities and compliance verification. Adopting this section standardizes application processes across all health facility and agency types.

Adopt subdivision (a) to establish that an applicant must submit a complete application and licensing fees to the Department to commence the application process to obtain a license. The applicant must use the most recent versions of all application forms as applicable when completing an application for initial licensure, initial licensure to add a multiple location, license suspension reinstatement, or another change as specified in section 74828. This is necessary to provide additional clarity and specificity

to the requirements in HSC 1748(b). These provisions ensure applicants use current forms and pay required fees, supporting accurate processing and compliance. The statute explains that if anyone wants to establish a hospice agency, they must complete an application prescribed and furnished by the Department. The Department needs these requirements to clarify that the application submission is associated with licensing fees, that the application forms used must be the most recent version available, and the types of cases when an application must be used such as establishing a hospice agency for the very first time (during initial licensure).

Adopt subdivisions (b) and (b)(1) through (b)(7) to establish that an application must include a cover letter which must include the following based on the application type: (1) The current name of the hospice; (2) The hospice's license number, if applicable; (3) A brief explanation of why the application is being submitted to the Department; (4) Contact information for the applicant, including, but not limited to, name, title, phone number, and email address; (5) Emergency contact information which the Department may use to contact the provider 24 hours a day, seven days a week, in the event of an emergency. Contact information includes, but is not limited to, name, email, alternate email, phone number, fax, and a phone number that will receive text messages; (6) Signature of the applicant; and (7) The proposed name for the hospice, if altering due to a change of ownership. These requirements are necessary to establish the standard application materials that an applicant must provide to the Department. Requiring a cover letter with the information listed in (b)(1) through (b)(7) will improve efficiency in the Department's review process because it clarifies the overall intention and the purpose of the application. The cover letter helps to immediately highlight key information about the applicant right away, making it easier to identify during the application review process. Including emergency contact information ensures the Department can reach the provider promptly in urgent situations. This regulation is necessary to align with the Department's current practice.

Adopt subdivisions (c) and (c)(1) through (c)(34)(F)(iii) to establish a list of required content in the application. This subdivision specifies detailed application content requirements currently collected by the Department. Most of the requirements are fundamental in nature, self-explanatory, and reasonable to request. These include basic information such as the applicant's name and contact details, organizational structure, history of disciplinary actions, property ownership, contractors' information, as well as documents and forms from various governmental agencies. The Department requires the following supporting documentation to evaluate the application and determine that the applicant is able to operate the hospice in compliance with regulatory requirements:

Subdivision (c)(8). Applicants must provide a government-issued photo ID to confirm identity, consistent with standard practices of other state agencies. A driver's license, state identification card, passport, or military ID are all very common types of photo IDs that the public possesses. Various government entities such as the Employment Development Department and Covered California also collect these forms of identification as part of their standard

practices.^{7 8} This documentation is necessary to confirm the identity of the applicant and to prevent additional cases of identity theft which can lead to fraud.

Subdivision (c)(10). This subdivision clarifies HSC section 1749(a)(1) which requires the applicant to demonstrate good moral character if the applicant is a franchise, franchisee, firm, association, organization, partnership, business trust, corporation company, political subdivision of the state, or governmental agency. Requesting documents such as filing statements endorsed by the Secretary of State (SOS) – including articles of incorporation or organization, partnership agreement, or signed resolutions – will help confirm the person in charge of the entity has good moral character because these documents serve to prove that the entity is in a good standing with the state of California.

Subdivision (c)(16). Proof of financial funds are necessary to demonstrate that the applicant is financially stable and possesses the necessary assets and resources to successfully finance and operate a hospice. This requirement is necessary to prevent hospice agencies from being created and sold as profit-seeking endeavors for illegitimate hospice agency operators.

Subdivision (c)(18) and (19). Applicants must provide proof of general liability and workers' compensation insurance to protect patients and employees and reduce fraud risk. Collecting proof of insurance coverages is intended to compel the applicant to be insured and ensure that the hospice and its employees are protected. This requirement proves that the applicant is responsible and is committed to operating a hospice in good faith. Adopting this regulation and enacting stricter licensing requirements will also help to reduce some of the fraudulent activities that have occurred within the hospice industry. This proposal (among many others discussed in this section) would make it more difficult for bad actors to obtain licensure because they would need to provide additional documentation which would hopefully deter them from attempting to obtain a license. General liability insurance covers potential damages for the premises and operation of the hospice. Workers' compensation protects and compensates employees for injury or illness occurring in the workplace. Medi-Cal requires the general liability coverage to be in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000.⁹ It is reasonable to

⁷ Covered California, Documents to Confirm Eligibility, Proof of Identity, Retrieved on January 29, 2025, <https://www.coveredca.com/documents-to-confirm-eligibility/identity/>.

⁸ Employment Development Department (EDD), Identity Verification for Unemployment, Retrieved on January 29, 2025, <https://edd.ca.gov/en/unemployment/identity-verification/>.

⁹ California Department of Health Care Services (DHCS), Insurance clarification for Medi-Cal enrollment, Retrieved on January 29, 2025, https://www.dhcs.ca.gov/provgovpart/Documents/PAVE_Project_for_Provider_Enrollment_Division/INSURANCEREQUIREMENTCLARIFICATIONWFORM.pdf.

require the minimum coverage amount of the worker's compensation to match the minimum amount of general liability insurance for consistency purposes.

Subdivisions (c)(20) and (c)(20)(A) through (c)(20)(D) listing the acceptable federal IRS tax documents that would help prove the validity of the hospice agency.

Subdivisions (c)(21). The Department must know what types of services the hospice agency is proposing to provide to patients. This requirement ensures the hospice develops and submits an appropriate service plan that will help provide the best quality care to patients. It is also necessary for the Department to collect this information for accurate data reporting.

Subdivision (c)(21)(A). A hospice service plan outlining how many employees will need to be hired to effectively manage the hospice and effectively provide all proposed services to patients is vital for the Department to confirm the hospice has all funding and resources necessary to carry out the plan. Additionally, including each employee's professional scope is necessary to guarantee sufficient staffing will be available to successfully provide all proposed services to patients.

Subdivision (c)(21)(B). This regulation is necessary to protect the health and safety of patients by ensuring the Department has current contact information for any medical professionals providing contracted services. This is also necessary to promote trust and communication between the Department and the regulated community.

Subdivision (c)(21)(C). Hospice agencies are statutorily required to provide volunteer services under HSC section 1749(d)(5), and volunteers are frequently used to provide everyday care for patients in between visits from the patient's RNs and LVNs. It is therefore reasonable and necessary for the Department to request this information prior to granting licensure. If the hospice agency does not have a reasonable plan in place for how it will attract and properly train hospice volunteers, this could put the health and safety of patients at risk.

Subdivision (c)(22)(C) for the same reasons as subdivision (c)(8) above.

Subdivisions (c)(22)(D) and (E) which are reasonable requests to have on file for individuals with five percent or more direct or indirect ownership interest or control interest in the hospice. If the individual is a medical professional, a current copy of their license is necessary to confirm the person's status is in good standing and they are fit to oversee a hospice agency. A social security number is basic information necessary to re-confirm the individual's identity.

Subdivision (c)(22)(G) to protect the health and safety of patients. The Department must be made aware of prior adverse actions to prevent unfit and

untrustworthy individuals from owning or managing hospice agencies. This requirement allows the Department to review a wide variety of relevant materials upon an applicant's request for licensure. Having these materials on file will also be helpful to expediently perform any future complaint investigations.

Hospice agencies care for the most vulnerable patients experiencing the last stages of life, and their families are often distressed and emotionally overwhelmed. It is therefore necessary to ensure the listed individuals have not acted in an inappropriate manner within the last 10 years. The Department considered a lookback period of seven years but believes that 10 years is a reasonable and necessary period of time to establish whether there have been adverse actions, or a pattern of adverse actions that indicate irresponsible financial behavior or failure to prioritize patient health and safety. In addition, adverse actions such as legal settlements can take several years to reach. Thus, seven years is therefore not robust enough, and the 10-year timeframe is a better choice because it is aligned with the resume request in subdivision (c)(22)(F). The Department does not wish to be overly burdensome by accounting for all instances throughout owners' and managers' lives yet needs to do its due diligence to protect the safety of patients. The Department does not believe that production of the required information is overly burdensome because the documents are public except for settlement agreements and are not onerous for the applicant to provide to obtain licensure. The purpose of requesting documents associated with settlements is to protect the public from situations where the underlying complaint may have been resolved but a concern for public or patient safety still exists. Similarly, actions resolved by bankruptcy, foreclosure, or judgment may reflect resolutions that were in the best financial interest of the hospice agency and associated entities and not the best interest of the public or the patients. License revocation, suspension, decertification, and probations could be indicative of a hospice agency's inability to properly serve the patients or the public, and the Department is requesting this information before licensure is granted. Receiverships and temporary managers are used when the Department must take quick, effective action under HSC 1325.5 because the residents of a long-term health care facility are in immediate danger of death or permanent injury because the facility is not in compliance with applicable state or federal requirements. These actions are indicative of a facility owner's or manager's inability to protect patient life, health, and safety.

Subdivision (c)(23). Knowing how much time administrators and their designees spend in the hospices is important for transparency purposes. This information will provide the Department with insight into their activities and help ensure their involvement in daily operations of the hospice. This will make it more difficult for fraudulent activities and unethical behaviors to go unnoticed, helping the Department to monitor their actions. The same concept applies to administrators and administrator designees managing multiple hospices in rural areas. The Department will be able to ensure that these individuals would be available at each agency equally, and adopting this regulation will fulfill that commitment.

Subdivision (c)(24). This subdivision was included to enforce the current statutory requirement under HSC section 1749(b)(2) relating to Medical Director certification. First and foremost, it is important to distinguish that this is separate from a Medical Director's licensure. A current, valid, and unrestricted license is required for all hospice Medical Director, but hospice Medical Director certification is a voluntary program that can be completed to demonstrate expertise in hospice care. While it is not a requirement for Medical Directors to hold such certification, if a Medical Director has elected to receive such certification on their own accord proof of certification must be submitted to the Department for proper recording.

Subdivisions (c)(25) through (c)(30). These subdivisions are necessary to enforce HSC section 1749(b)(1). All hospice agencies must employ management personnel which specifically include an administrator, a director of patient care services, and clear designees for each position. The substantiating documents such as a list of all hospice agencies these individuals are currently serving, fully endorsed executed contracts, listed history of any misdemeanors or felonies are necessary for the Department to verify the qualifications of each management position and effectively enforce the statute.

In addition to this, the Department is mandating the role of the Medical Director Designee for hospice agencies. It is reasonable to require a Medical Director to have a designee with all the same qualifications above when the primary Medical Director is not available. This is necessary for consistency with the other management personnel (Administrator and Director of Patient Care Services) which are currently required to have designees. Furthermore, a Medical Director Designee is currently required at a federal level. Title 42 of the Code of Federal Regulations (CFR) section 418.3 defines:

“Physician designee” as a Doctor of Medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Title 42 CFR 418.102 states:

The hospice must designate a physician to serve as medical director. The medical director must be a Doctor of Medicine or osteopathy who is an employee or is under contract with the hospice. When the medical director is not available, a physician designee as defined at § 418.3 assumes the same responsibilities and obligations as the medical director.

The concept of the “Medical Director Designee” is the same as a physician designee with a different naming convention. Adopting this regulation is also necessary to align with federal regulations.

Subdivision (c)(31). This information is necessary for the Department to accurately verify and confirm the legitimacy of the hospice agency. The purpose of a fictitious business name is to help a business connect with its target audience and enhance its market presence, instead of operating under the licensee's legal name. This is common industry practice, and therefore this information is necessary for the Department to record and identify the hospice agency.

Subdivisions (c)(32) and (c)(32)(A) through (c)(32)(D) are necessary to prove that the hospice agency's proposed service area meets all essential requirements of section 74820 (Geographic Service Area).

Subdivision (c)(32)(A) identifies the basic information of each county within CA that the hospice is proposing to serve. This information is necessary for the Department to be able to accurately perform the GSA calculations of section 74820 and confirm whether each identified county meets all applicable criteria. If a listed county does not meet all requirements, and does not have an unmet need for services, it cannot be approved for service, and the Department would need to notify the hospice agency that the specific county must be removed from their service area. For further justification please refer to section 74820 and section 74832 (Denial of Application) subdivision (a)(6).

Subdivision (c)(32)(B) remains consistent with current practice for hospice licensure. This documentation provides a visual representation of the hospice agency's proposed service area.

Subdivision (c)(32)(C) is necessary for the Department to review how the hospice agency calculated its GSA and verify that the proposed GSA meets all requirements of section 74820 subdivisions (c) and (d). For further justification please refer to section 74820.

Subdivision (c)(32)(D) is needed to ensure that any multiple locations added by a hospice agency are also compliant with the 2-hour distance limitation under section 74820. Under HSC section 1746(i), any newly added multiple location would be subject to the same limitations as the previously approved GSA of the parent agency, however this regulation is necessary to clarify that the hospice must submit documentation proving compliance for the Department to review and approve prior to the multiple location being added. This will help prevent hospice agencies from attempting to service unreasonably large GSAs, which could put the health and safety of patients at risk because hospice personnel are unable to arrive in a timely manner.

Subdivisions (c)(33) and (c)(33)(A) through (c)(33)(C)(iv). The Department is the State Survey Agency for California designated to perform surveys on behalf of the Centers for Medicare and Medicaid Services (CMS). One of the primary responsibilities of the Department is to conduct surveys to verify whether

hospices are adhering to the CMS Conditions of Participation (CoPs), ensuring they meet all necessary standards for patient safety and quality of care. If the applicant and the hospice meet those standards, the applicant/hospice will be certified to participate in the Medicare program, allowing the hospice to provide services to patients who are eligible for Medicare. The Department collects Medicare-related information during the application process to verify that the applicant is compliant with necessary laws and regulations to ensure quality of patient care and safety. Collecting these documents during the licensure process creates efficiency for those applicants seeking both licensure and certification. All necessary forms are incorporated by reference to clarify the exact forms the Department is requesting. Of note, the federal HHS 690 form was not incorporated by reference because it is currently expired and undergoing rulemaking to be updated. The Department is therefore requiring proof of electronic completion to CMS as part of the application process which is consistent with current practice.

Subdivisions (c)(34) and (c)(34)(A) through (c)(34)(F)(iii) for the same reasons as subdivision (c)(33). The Department has an interagency agreement with the California Department of Health Care Services (DHCS). DHCS administers and oversees the Medi-Cal program. Medi-Cal is California's Medicaid program, which is a public health insurance program which provides needed health care services for low-income individuals. CDPH and DHCS collaborate to ensure patient safety and quality of care. CDPH collects Medi-Cal related documentation and information during the application process to verify if the applicant is compliant with all necessary laws and regulations for quality of patient care and safety. Collecting these documents during the licensure process creates efficiency for those applicants seeking both licensure and certification. Forms are incorporated by reference to clarify the exact forms the Department is requesting.

Adopt subdivisions (d) and (d)(1) through (d)(3). Applicants must sign and date the application to make it legally binding. Authorized signatories may sign if accompanied by photo ID. A signature and date from the applicant are necessary to ensure that the application is legally binding and enforceable. The basic execution of signing usually involves a legal name, date, and a job title. The Department also accepts an authorized signatory as a signer to provide flexibility to the applicant when they are unable to sign and date an application due to unforeseen circumstances. A photo ID is required to confirm the legitimacy of the authorized signatory.

Adopt subdivisions (e) and (e)(1) through (e)(3). Applicants must acknowledge compliance with local ordinances and health codes to establish accountability. Requiring an applicant to formally acknowledge their intent and commitment to comply with local ordinances, labor codes, and health and safety codes is necessary to establish accountability. Requiring the applicant to formally agree to these requirements will also help make the application itself enforceable.

Adopt subdivision (f). Retaining a copy of the application ensures record accessibility. This is necessary for the Department to have easy access to records upon request.

Adopt subdivision (g). The Department may request additional information under Health and Safety Code section 1748(b) to complete its evaluation. This requirement is necessary to ensure that an applicant is properly evaluated for hospice licensure. While the majority of the requirements listed in this section should be sufficient to assess the applicant's qualifications, there may be instances where the Department requires additional information for a more comprehensive evaluation, ensuring all criteria for licensure are met and the applicant is thoroughly vetted. HSC section 1748(b) gives the Department authority to request information the Department deems necessary to fully evaluate applicants. Also, there are times where there is simply an oversight of information from the applicant. In these situations, the Department currently allows 60 days for the applicant to remedy this oversight and adhere to the Department's request. Along with ensuring proper evaluation of an applicant, this regulation is necessary to align with Department's current practice and establish a transparent process within Title 22 regulations.

Adopt section 74816 "Licensing Fees."

This section establishes licensing fee requirements to provide clarity for providers regarding when fees apply. The regulated community pays close attention to the rules related to fees because it affects the finances of the hospice. Providers often have questions about when fees apply, and this section is necessary to provide clarity to the regulated community. These requirements are adopted pursuant to Health and Safety Code sections 1750(a) and 1266.

Adopt subdivision (a) to establish the requirement that hospices must submit a licensing fee with new and renewal applications, consistent with industry practice. This provision clarifies statutory requirements under Health and Safety Code sections 1750(a) and 1266. Requiring a licensing fee to be submitted along with new and renewing licensing applications is common industry practice for nearly all Title 22 facility types. HSC section 1750(a) of the California Hospice Licensure Act specifically addresses and requires an annual fee to be accompanied with an application "in accordance with HSC section 1266." Referencing statutory authority ensures applicants understand that fee requirements are legally mandated.

Adopt subdivision (b) to establish all instances when a fee is required and mandates that payments be made payable to the Department to prevent errors and ensure transparency. This requirement is necessary to further clarify for the regulated community every instance a fee is required, and that each fee must be made payable to the Department. This is important because requiring the applicant to specify the exact recipient of the payment, and what the payment is for will reduce discrepancy and prevent potential errors.

Adopt subdivision (c) because having a no refund policy is consistent with other Title 22 facility-types such as GACH regulations under section 70110(b), Skilled Nursing

Facility regulations under section 72203(a)(1), and Immediate Care Facilities under section 73208(a)(1).

Adopt subdivision (d) to establish that while multiple locations do not require separate licenses under Health and Safety Code section 1748(a), the parent hospice must pay a separate licensing fee for each location. This ensures equitable fee collection and operational transparency.

Adopt Section 74820 “Geographic Service Area.”

Section 74820 establishes standards for determining hospice service areas, addressing concerns identified in the Audit Report.¹⁰ This section effectuates Health and Safety Code section 1753.1(a). According to the Audit Report, there are extreme cases of a hospice being licensed to serve over 30 counties in California spanning over 100 miles, which could potentially result in unreasonably long response times and ultimately low-quality of care to patients and their families. HSC section 1753.1(a) requires the Department to set a standard for how far hospice agency personnel are allowed to travel to care for patients.

Adopt subdivision (a). Subdivision (a) limits hospice travel time to two hours, as required by Health and Safety Code section 1753.1(a). This standard ensures timely nursing care for terminally ill patients. When determining the most appropriate response times for hospice nurses, the Department looked at the response time requirements of other similarly related Title 22 facility types for consistency such as Home Health Agencies (HHAs) under California Code of Regulations (CCR) section 74607(a). HHAs are required to remain within a four-hour travel time from the parent agency location, however unlike HHAs, hospice agencies are focused on serving terminally ill patients who often experience sudden unexpected declines in their health condition. Department surveyors have observed that when hospice personnel travel long distances to get to their patients, this extends the most painful moments of end-of-life suffering. This was especially important to keep in mind for patients living in remote or rural areas where it can be more difficult for agencies to recruit qualified personnel.

The Department proposed this requirement in a stakeholder meeting and carefully considered all feedback from the regulated community, along with input from internal subject matter experts, and determined two hours to be the most reasonable response time to appropriately balance the need for timely care with access for all. This proposed regulation is necessary to prevent delays in care and ensure that patients who experience a sudden decline in health can maintain their dignity and receive needed comfort during the dying process.

Adopt subdivision (b). Subdivision (b) requires hospices to maintain policies for telephonic or remote support until a nurse arrives, ensuring immediate assistance for patients and caregivers. This requirement is necessary to specify policies and procedures that need to be created and made available to hospice personnel that

¹⁰ Audit Report at pg. 33.

explain protocols for how to support a patient telephonically, or via another appropriate remote method, until a nurse arrives to provide in person assistance. This is necessary because patients, and their caregivers who are providing around-the-clock support to a dying loved one, are likely fatigued, distressed, and emotionally overwhelmed; these individuals need and deserve immediate support and guidance from the agency until a nurse is able to arrive in person.

Adopt subdivision (c). Subdivision (c) requires hospices to establish a geographic service area within the two-hour travel limit, calculated from the parent agency address. This is necessary to fully effectuate subdivision (a) and clarify that all hospices must establish a geographic service area (GSA) that falls within the two-hour travel time limitation. This subdivision also clarifies that the distance calculations used to determine a GSA must begin from the parent hospice agency's address. This is necessary to ensure that hospice patients accepted for service reside close enough to the agency and that personnel will not be forced to drive long distances to reach them, which would impede their ability to meet the 2-hour response time requirement of this section.

Adopt subdivision (d). Subdivision (d) clarifies how hospices must calculate service areas based on geographic conditions, ensuring equitable application of the two-hour standard. This requirement is necessary for the same reasons as subdivision (c) and to clarify to the regulated community how a geographic service area must be established. Subdivisions (d)(1)–(d)(3) establish standardized methods for calculating and documenting service areas, including peak traffic sampling and timestamp requirements, to ensure compliance with the two-hour limit.

Distance values will vary greatly for each hospice depending on where a hospice is located and what type of areas are being served. For example, the distance personnel would be able to travel in a densely populated urban city at peak traffic time will be significantly less than the distance personnel in a rural area would be able to travel experiencing little to no traffic. This proposed regulation is necessary to ensure service areas are calculated in a way that is tailored specifically for each hospice's geographic condition, while still being equitable by requiring all applicants to follow the same set of parameters.

Adopt subdivision (d)(1) to establish how and when the two-hour distance calculations must be measured. Determining a hospice service area is not a one size fits all approach because many different factors can affect a hospice's ability to reach patients in a timely manner, such as whether the hospice is located in an area that experiences high levels of traffic.

The Department's intent when developing this calculation model was to ensure hospice staff would be able to reach patients without unexpected delay, and have no issues being compliant with the requirements of this section. The Department was also conscious about making sure hospice GSAs were calculated in an equitable way. For example, requiring all hospices to take their samples starting from the address listed on their application (also known as the "parent agency") helps establish a common

baseline among all prospective applicants. Requiring the samples to then be taken during peak traffic time on a regular non-holiday weekday is important to get an accurate representation of the typical traffic conditions for that specific area. This is necessary to account for the added time it will take staff in urban areas to reach patients during those hours, which the Department was statutorily required to consider under HSC section 1753.1(a).

The information collected in this subdivision is critical for determining which counties can reasonably be included in an applicant's GSA while remaining compliant with the requirements of this section. It is also necessary to ensure an appropriate and equitable service area calculation for all prospective applicants.

Adopt subdivision (d)(2) to establish how an applicant for hospice licensure must reach a final service area determination. Requiring an applicant to use the average of the gathered samples is necessary because although the distance measurements taken in subdivision (d)(1) already account for peak traffic conditions, only allowing hospices to operate within the average of those distance values will create a safeguard to ensure hospice personnel will still be able to meet the two-hour response time requirement should an unforeseen circumstance occur. Establishing instructions for how to identify an average radius is necessary to ensure that all applicants reach a final determination of what the maximum travel distance for their individual area is in a consistent manner.

Adopt subdivision (d)(3) requiring a hospice to submit documentation that shows the Department how the agency executed subdivisions (d)(1) and (d)(2) to determine its GSA. Every hospice licensure application must complete these steps as required under section 74812 (Content of Application), and requiring proof of the agency's calculations allows Department staff to verify and confirm that all counties included in the proposed GSA do not exceed the two-hour response time limitation of this section. This proposed regulation also clarifies that the agency must include a timestamp of when the samples were taken to confirm that the hospice submitted a recent and accurate representation of traffic patterns in its area. This proposed regulation is necessary to ensure the Department is able to verify the information used to determine a hospice GSA and protect the health and safety of patients by denying any counties listed for service that extend beyond the two-hour response time limit.

Adopt subdivision (e). Subdivision (e) defines "unmet need" to establish filtering criteria to ensure equitable review of hospice applications. This is necessary to clarify to the regulated community that a hospice agency's GSA must only include counties that have an unmet need for hospice services. The Department has a statutory obligation under HSC section 1749(f)(1) to ensure that hospices are only granted licensure in areas where there is a proven need for such services, however the language used in statute is ambiguous and would be difficult for Department surveyors to enforce. This proposed regulation is necessary to effectuate HSC section 1749(f)(1), and necessary to point out that the Department defined the term "unmet need" for additional clarity which can be found in section 74800(a)(56).

Adopt subdivision (f). Subdivision (f) establishes a calculation model using standardized data sources and filtering criteria to ensure equitable review of hospice applications. This is necessary to set a new standard and clarify to the regulated community exactly how “unmet need for hospice services” must be determined. Subdivisions (f)(1)–(f)(5) outline steps for calculating unmet need, including identifying potential patients, assessing current hospice capacity, and comparing values to determine service gaps. These steps ensure transparency and prevent over-licensing. For the same reasons stated above in subdivision (e), all hospice GSAs will be screened for approval based on the calculation model in this subdivision which includes initial licensure applications and change of geographic service area applications.

The Department did extensive research on the topic of “need” for hospice services. There are currently only two other states that follow this concept: New York has hospice regulations for “Determinations of public need for hospice” under section 790.16, and Florida has certificate of need regulations in place with specific criteria any new hospices are required to meet.^{11 12} The Department analyzed and considered these formulas during the research and drafting of this section, however decided not to adopt either of these formulas because they are overly complicated and could not be easily adopted. The Department instead developed an entirely new model that is tailored specifically for California by using the most recent available data to look at the individual demographic information for every county within the state. Using current data for each individual county is important because California has a wide range of diversity throughout the state, with some areas being rural and scarcely populated and other areas being urban and very densely populated, so all the different counties will have dramatically different needs and this model will allow interested parties to objectively and unbiasedly see if there is a need for more services in an area. This proposed regulation is a necessary because it provides the public and the Department with a tool that will transparently and unbiasedly determine if a county in California has an “unmet need” for hospice services pursuant to HSC section 1749(f)(1), which will then determine if a county can or cannot be included in a hospice’s GSA.

Adopt subdivision (f)(1) to establish how to identify the number of potential hospice patients there are in a specific county. This is necessary because it is the first step in determining if an “unmet need for hospice services” exists to approve or deny an application for hospice licensure. Subdivision (f)(1) sets the standard for specific data sources and specific filtering criteria to be used to guarantee that all applications for hospice licensure are reviewed under uniform and unbiased conditions.

Adopt subdivision (f)(1)(A) to begin identifying the number of individuals who are likely eligible for hospice care in a specific county. This subdivision is necessary to guarantee that the data for this step in the calculations is always taken from the California Health and Human Services (CalHHS) Open Data Portal website, specifically the “Deaths

¹¹ N.Y. Comp. Codes R & Regs. Tit.10 § 790.16

¹² Fla. Admin. Code R. 59C-1.0355 (2024).

Profiles by County” dataset.^{13 14} The Department determined that CalHHS was the best source of information to use because the data in this site is collected directly from hospice agencies operating within the state of California and is maintained regularly by a reputable agency. Additionally, CalHHS is the only reputable site that maintains data at the county level which is necessary to complete the calculations of this section. Hospice licensure applications vary greatly for the proposed service areas therefore the dataset used by everyone needed to be customizable to account for each individual county in California. The “Deaths by Year by County” dataset is the most appropriate source to accomplish this goal.

Adopt subdivision (f)(1)(B) to set specific filtering criteria for how to use the required Cal HHS “Final Deaths by Year by County” dataset. Requiring all persons using the unmet need tool to apply the same filter settings is necessary because it ensures there will not be any outliers included that could skew the data and the results. For example, if two different hospice agencies wish to provide care in a county, both agencies would be subject to the same filtering criteria to ensure all hospice GSAs are approved in a consistent and unbiased manner. This proposed regulation is necessary to ensure consistent review for all applicants.

Adopt subdivision (f)(1)(B)(i) to require the “year” column to be filtered to include all available years. It is necessary to use as many years as possible to find a true representation of the average number of deaths that occur in each county per year and to avoid any outliers that may potentially skew the data.

Adopt subdivision (f)(1)(B)(ii) to require the “county” column to be filtered to one county the hospice wishes to serve. This is necessary to look at the data from the county that will be served by the hospice to determine whether that specific area has a need for hospice services. If the hospice intends to serve multiple counties, additional steps will need to be taken as discussed in a later subdivision.

Adopt subdivision (f)(1)(B)(iii) to require the “geography type” column to be filtered to “residence.” This is important to avoid any outliers of people who may have traveled or been transferred and passed away from cancer in one county but were not a resident of that county. Focusing on the residents of the specific county will provide the most accurate representation of the need for hospice services in that area.

Adopt subdivision (f)(1)(B)(iv) to require the “strata” column be filtered to “total population.” This is important because all deaths caused by cancer in the community

¹³ California Department of Public Health, “*California Health and Human Services Open Data Portal*,” Last accessed October 24, 2024, <https://data.chhs.ca.gov>.

¹⁴ California Department of Public Health, “*California Health and Human Services Death Profiles by County*,” Last accessed October 24, 2024, <https://data.chhs.ca.gov/dataset/death-profiles-by-county>.

regardless of age, gender, or race-ethnicity should be used to determine if there is a need for hospice services in a county.

Adopt subdivision (f)(1)(B)(v) to require the “cause” column to be filtered to “CAN” which represents deaths by cancer. This is necessary because according to the National Hospice and Palliative Care Organization (NHPCO), cancer is the leading principal diagnosis (30%) among Medicare hospice patients.¹⁵ Heart disease was the next leading diagnosis (18%), however heart disease has a low hospice utilization rate which would greatly skew the methodology and undermine the intent of determining whether or not there is a true need for hospice services in a county.

Adopt subdivision (f)(1)(C) to clarify how to find the average of all cancer deaths per year in a county from the above filtered dataset. The information provided in subdivision (f)(1)(B) will show a total number of deaths for each individual year, however, to complete the calculation requirements of this section the average number of cancer deaths across all available years must be identified. It is important to use the average of all years because that will provide a more accurate representation of diagnosis trends and will remove any potential outliers from skewing the data. This proposed regulation is necessary to ensure the correct value is identified because this information must later be used to complete the unmet need calculations of this section.

Adopt subdivision (f)(1)(D) to account for potential hospice patients with a diagnosis other than cancer which is necessary to get the most accurate representation of the demand for hospice services in a county. Following with the statistic identified in subdivision (f)(1)(B)(v) which states 30% of hospice patients had a principal diagnosis of cancer, that leaves a 70% gap that must be incorporated to account for all other hospice patients with a diagnosis other than cancer to reach 100% inclusion. The Department determined that the best way to achieve 100% inclusion is to multiply the average of all cancer deaths by 0.7% to find the average number of non-cancer hospice patients.

Adopt subdivision (f)(1)(E) to establish that the value identified in subdivision (f)(1)(C) must be added with the value identified in subdivision (f)(1)(D) which is necessary to get the most accurate representation of how many potential hospice patients are in a county regardless of their diagnosis.

Adopt subdivision (f)(1)(F) to establish how the first series of calculations in the unmet need formula must be completed. This is necessary because the identified total average number of individuals who are likely eligible for hospice care will later be compared with the total average number of patients that the hospices currently operating can accommodate to reach a final determination if there is unmet need for hospice services in a county.

¹⁵ National Hospice and Palliative Care Organization, “*Facts and Figures 2020 Edition*,” August 20, 2020, <https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf>.

According to a 2019 study by the American Geriatrics Society, 50% of cancer patients who are eligible for Medicare do not use the hospice services available to them.¹⁶ The Department therefore determined that the best way to determine the number of patients who are both eligible and likely to use Medicare hospice services is to multiply the number of potential hospice patients in a county by 0.5 (or 50%). Having a standard for determining how many patients need and are likely to use hospice services in a county is also a necessary first step needed to complete the “unmet need” formula of this section.

Adopt subdivision (f)(2) to set a standard for how to calculate and identify the average number of patients the current hospices in each county can accommodate. This is the necessary second set of calculations that must be used to reach a final determination if there is an unmet need for hospice services in a county.

Adopt subdivision (f)(2)(A) to direct individuals performing the calculations of this subdivision to a single source of data. Allowing only one data source to be used is necessary to ensure all calculations and determinations are equitable for all hospice licensure applicants. The Department determined that the “Find and Compare a Health Care Facility” search feature is the most appropriate source of data to use because the Department is solely responsible for licensing hospices in the state of California and therefore has the most comprehensive and current information regarding the licensure status of hospices operating in the State.¹⁷

Adopt subdivision (f)(2)(B) to set specific filtering criteria for how to use the required “Find and Compare a Health Care Facility” search engine. This is necessary to ensure that the unmet need calculations in this model are performed in a uniform manner, and therefore all hospice licensure applications are reviewed and approved or denied equitably.

Adopt subdivision (f)(2)(B)(i) to require the “facility name” section to be left blank to ensure that all hospice agencies operating in the county are accounted for. This is necessary to get a true representation of how many hospices are currently licensed in a county and accurately complete the unmet need calculations of this section. This information will later be compared with the number of potential hospice patients in the

¹⁶ John G. Cagle PhD MSW, Joonyup Lee MSW, Katherine A. Ornstein PhD, Jack M. Guralink MD PhDASG Geriatric Healthcare Professionals, “*Hospice Utilization in the United States: A Prospective Cohort Study Comparing Cancer and Noncancer Deaths*,” December 27, 2019, <https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.16294>.

¹⁷ California Department of Public Health, “*Cal Health Find Database*,” Last accessed October 24, 2024, <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx>.

county as identified earlier to determine if the existing hospices are capable of handling all the demand for hospices services in that county or not.

Adopt subdivision (f)(2)(B)(ii) to require the hospice's primary county information such as zip code, city name, or county name which is necessary to receive the most accurate information for that area to perform the required calculations of this section.

Adopt subdivision (f)(2)(B)(iii) to ensure "hospice" is the only checked facility type from the drop-down menu. This is necessary because "hospice" refers to hospice agencies and including information from any other facility type such as "hospice facility" which is an additional option would skew the data for determining unmet need for hospice agency services and undermine the intent HSC section 1749(f)(1).

Adopt subdivision (f)(2)(B)(iv) to ensure that all "types of care & services" currently offered by a licensed hospice in a county is captured and considered. This is necessary to receive an accurate representation of all licensed hospices in a county regardless of the services they offer. Leaving any operational hospices out would affect the final unmet need determination of this section.

Adopt subdivision (f)(2)(C). This proposed regulation is necessary to clarify that the steps taken above in subdivision (f)(2)(B) will lead the individual to the total number of licensed hospices in the identified county. That value must later be used to complete the unmet need calculations of this section.

Adopt subdivision (f)(2)(D) to set a standard for how the third and final set of calculations for determining unmet need must be completed. This subdivision identifies approximately how many patients all the currently licensed hospices in the county are able to admit and accommodate, which will be necessary to compare with earlier calculations of approximately how many patients are in need of hospice care in a county.

According to the Audit Report, at that time, there were 56 patients per hospice outside of LA county and four patients per hospice in LA county.¹⁸ The Audit Report also found that in LA county there were clusters of fictitious hospice agencies enrolling patients without their knowledge and billing Medicare for services that were never provided. This is likely what skewed the numbers of patients per hospice so low. Therefore, the Department concluded that 56 patients per hospice is more reasonable and should be used as the average standard.

Multiplying the total number of actively licensed hospices in a county by 56 is therefore necessary to identify the total average number of patients that the currently licensed hospices in the county would be able to accommodate and accept for services.

¹⁸ Audit Report at pg. 1

Adopt subdivision (f)(3) for full transparency to the regulated community that the calculation requirements of this section used to determine unmet need in a county may be automated or performed by a representative of the Department. This is necessary to ensure to current or future applicants for hospice licensure that if an automated system is used to perform the calculations, the Department ensures the results will be the same as performing the calculations manually pursuant to the steps required in (f)(1) and (f)(2) of this section. This is also necessary to reassure applicants that the unmet need calculations of this section will be performed by the Department and are not intended to be the responsibility of the applicant. This will help ensure the results for every application remain equitable regardless of them being automated or performed manually.

Adopt subdivision (f)(4) to establish and explain to the regulated community how all the required calculations of this section must be used together to make a final determination of how “unmet need” for hospice services is to be identified. This is necessary to clarify and fully effectuate HSC section 1749(f)(1) and give the Department’s Centralized Applications Branch the tools it needs to appropriately approve or deny the proposed service areas listed on hospice licensure applications in an equitable way.

Adopt subdivision (f)(5) to ensure that each proposed county for service listed on a hospice licensure application is reviewed in a consistent manner. This is necessary for the Department to verify that each individual county qualifies under the “unmet need” requirement of this section before granting approval.

Adopt subdivision (g). Subdivisions (g)–(i) require Department approval for service area changes, prohibit unlicensed operations, and mandate compliance with unmet need calculations to protect patient safety and prevent fraud. This subdivision is necessary to make clear to the regulated community that any county listed for service on a hospice licensure application must individually be screened through the unmet need calculation model outlined in subdivision (f) and must result in an unmet need for hospice services or else it cannot be included in the hospice’s service area. This is necessary to effectuate HSC section 1749(f)(1) and not allow additional hospice agencies to become licensed in a county where is no identified need for additional services in the area. Furthermore, this will significantly reduce the likelihood of further hospice agency fraud in California.

Adopt subdivision (h) to ensure that a hospice agency does not alter its service area in any way without first receiving written approval from the Department. Requiring a hospice to submit a request to change its service area as outlined in section 74828 “Report of Changes” is necessary for the Department to be able to properly screen any new proposed counties and confirm that they qualify for approval pursuant to the unmet need calculations of subdivision (f). This proposed regulation is also necessary for accurate record keeping purposes. The Department must be able to track all hospice agencies that are actively licensed and operating in a county to provide effective oversight and because that information is necessary to complete the unmet need

calculation model of this section; the Department's Cal Health Find's "Find and Compare a Health Care Facility" feature specifically must be regularly updated and maintained to accurately complete subdivision (f)(2).

Adopt subdivision (i) to set a standard and make clear that a hospice cannot promote itself to the public or provide services to patients as a hospice agency without first obtaining documented licensure from the Department. This is necessary to maintain consistency with other Title 22 regulations such as Home Health Agencies, and to protect the health and safety of patients from hospice agencies who have not been properly evaluated or confirmed for meeting all state regulations and requirements.

Adopt section 74824 "Change of Ownership."

Section 74824 establishes requirements for change of ownership (CHOW) to ensure continuity of care and compliance with Health and Safety Code section 1748(d), which prohibits license transfers. If an existing licensee wishes to sell its business, the proposed new owner must independently apply for licensure before it can operate the hospice. The expansion of purchases of hospices by various entity types and the complex corporate structures of the entities seeking licensure calls for regulations to specify the vetting process for a CHOW and establish disclosures to ensure any new applicants/licensees meet all the required qualifications to operate the hospice. This section is necessary to provide clarity and specificity regarding the approval process when a CHOW occurs. Many provisions in this section align with current practices enforced by the Department, ensuring standardization and consistency throughout Title 22 health facilities application processes. These provisions are necessary to clarify the vetting process for new owners and align with current Department practices to prevent fraud and protect patient safety.

Adopt subdivisions (a), and (a)(1) through (a)(7). Subdivisions (a)(1)–(a)(7) define transactions constituting a CHOW, including majority ownership transfers, mergers, vertical integration, and asset transfers, consistent with Health and Safety Code section 1253.2(e) and Title 42 CFR section 424.502. These requirements are necessary to specify the types of transactions that constitute a CHOW, and when the requirements of an application should apply. Due to the lack of clarity in the hospice licensure act, the Department follows examples set forth in HSC section 1253.2(e), which contains well-established standards of CHOW for health facilities which are also applicable to hospice agencies. Examples of complex transactions include instances where a majority or portion of an entity that owns a hospice is transferred, or there is vertical integration of an entity, or mergers of entities that operate hospices, or transfer of assets or control of rights. These standards ensure proper vetting and oversight during ownership transitions.

Subdivision (a)(1) defines major change in ownership interest consistent with Title 22 CCR section 74667, which discussed ownership changes of home health agencies that have a 50% ownership change threshold for the submission of a new application. It is also consistent with Title 42 CFR section 424.502's change in majority ownership for HHAs and hospice agencies for initial enrollment into the Medicare program. The

proposed regulation is reasonably necessary because a change of 50% ownership provides the majority owners with the ability to control the operation of the entity and to also change the person(s) who are operating the entity, and therefore, the hospice agency.

Changes affecting nonprofit governance under Corporations Code (Corp.) section 5914 and leased property transfers are included because they alter organizational control and operational authority. Specific changes that relate to non-profits in reference to section 5914, and leased property are also being proposed to be part of what constitutes as a CHOW. This is reasonably necessary because an organization's control and direction is changed by majority changes on the governing board. Further, when the leased portion of a hospice is changed to a new entity or person, this circumstance allows for a new entity or person(s) to control the leased portion of the hospice.

Transactions mentioned above also align with what constitutes as a CHOW at the federal level under Title 42 CFR section 489.18. This subdivision is necessary to set standards which help to manage handling ownership transitions and proper vetting.

Adopt subdivision (b). Subdivision (b) requires submission of a CHOW application at least 120 days before the transaction, consistent with Health and Safety Code section 1253.3(a)(2). This timeframe allows thorough review and prevents unauthorized transfers. The Department proposes to require hospice agencies to submit a CHOW application at least 120 days before the transaction occurs. Due to lack of clarity in the hospice licensure act, the Department decided to mirror the 120-day submission timeframe for skilled nursing facilities as set forth in HSC section 1253.3(a)(2). The 120-day timeframe is reasonable and appropriate because it provides the Department with ample time to thoroughly review and approve a CHOW application. In addition, clarifying that a CHOW is not effective until approved by the Department ensures the regulated community is informed of this standard which will help to prevent illegal or unauthorized transactions and so reduce fraud. Furthermore, this subdivision specifically lists the additional documentation that must be included in a change of ownership application. Due to the complexity of a CHOW, it is appropriate to request further documentation in addition to what is required in section 74812 "content of application" to ensure the CHOW transaction is in accordance with all applicable laws and regulations. Subdivisions (b)(1)–(b)(6) require a cover letter, all application items listed in section 74812, proof of ownership transfer, and financial documentation to verify the prospective licensee's qualifications and ensure continuity of care.

Adopt subdivision (b)(1). Requiring a cover letter is beneficial because it clarifies the overall intention and the purpose of the application. A cover letter also helps to immediately highlight key information about the applicant, making it more convenient for the Department to identify during the application process and timely review the application.

Adopt subdivision (b)(2). The concept of a CHOW application and all related documents/requirements are the same as someone applying for a license for the very

first time. The new owner/prospective licensee has not yet been vetted or confirmed qualified to successfully operate a hospice. Therefore, the Department must receive all items listed in section 74812 to properly review and approve the newly proposed owner.

Adopt subdivision (b)(3) to distinguish between the current licensee and the prospective licensee.

Adopt subdivision (b)(4). The proposed effective date describes precisely when the CHOW is intended to go into effect, and when the prospective licensee would be legally required and obligated to perform their duties as a licensee. This subdivision is necessary for clarity among all parties involved, including the Department for accurate processing and record-keeping.

Adopt subdivision (b)(5)(A) to verify whether both the current licensee and the prospective licensee have met the requirements described in section 74896(o). For further details regarding medical records storage statement during CHOW, please refer to the corresponding section.

Adopt subdivisions (b)(5)(B) and (b)(5)(B)(ii). Supplemental documentation is required to be collected by the Department to serve as proof of valid ownership transfer. Examples include a preliminary purchase agreement and an operating transfer agreement. The preliminary purchase agreement outlines the terms of sale, while the operating transfer agreement details the operational responsibilities and obligations. These documents discuss conditions agreed upon by both parties involved containing elements of seller and the buyer, the percentage of ownership with signature and date. These written agreements help to ensure that the transfer complies with all relevant legal requirements and provides a formal record of transaction, verifying the legitimacy of the CHOW.

Adopt subdivision (b)(6). It is reasonable and necessary to request documentation from an applicant demonstrating that they have sufficient financial resources to operate the hospice. It is the Department's responsibility to assess and review the applicant's financial viability, and ability to manage the hospice, prior to approving a CHOW application to protect the health and safety of patients.

If the ownership transaction is based on gift donation, a statement of the relationship between the donor (gift giver) and the donee (gift receiver) is necessary to be collected because understanding the nature of the relationship helps the Department to verify whether the transfer is based on any undue influences, bias, or unethical practices. It maintains the integrity of the transaction by confirming that the ownership transfer is legitimate and not a disguised transaction or an attempt to evade legal or regulatory requirements.

Adopt subdivision (c). Subdivision (c) is necessary to clarify the exceptions under Health and Safety Code section 1748(f), allowing a CHOW to occur within five years only for continuity of care or financial hardship, supported by specific evidence. HSC

section 1748(f) is an exception to HSC section 1748(e), which places a “moratorium” for CHOW during the first five years of the hospice starting from the date a license was initially issued to the licensee. HSC section 1748(f) is an avenue for a CHOW to occur within the five-year period if the hospice agency demonstrates and provides evidence to the Department that there is either a need to ensure continuity of care for existing patients, or the hospice is facing a financial hardship, combined with a requirement to satisfy an unmet need in hospice’s respective GSA, as defined in 74800(a)(56).

The current statutory language, however, is unclear and unenforceable, as various circumstances can lead to discontinued care. Without specificity, a hospice agency could take advantage of the ambiguous statute and qualify for conditions in HSC section 1748(f)(1). The proposed language in this subdivision addresses the ambiguous structure of HSC section 1748(f) by clarifying that the CHOW is necessary to ensure continuity of care for existing patients when the current licensee is facing specific situations such as emergency conditions, limited resources and capacity, or a financial hardship. “The need to ensure continuity of care” described in HSC section 1748(f)(1) is measurable and enforceable under this regulation. Subdivisions (c)(1)–(c)(3) require evidence of emergencies, resource shortages, or financial hardship to justify CHOW within five years, ensuring objective and enforceable criteria.

Adopt subdivisions (c)(1), and (c)(1)(A) through (c)(1)(C) to require the hospice to provide specific evidence including emergency proclamation. These can be found in instances where a hospice experiences an official state of emergency. Such emergencies are typically declared by the Governor of California or by the local government authorities in response to critical situations such as natural disasters, pandemics, or other large-scale crises. During these times, essential services may be suspended or limited, including the ability to maintain consistent staffing, delivering routine medical care, and ensure that patients receive the level of attention and support they need. These disruptions can severely affect the quality of care for hospice patients, as their specialized needs may not be fully met under emergency conditions. Furthermore, the unpredictability of an emergency can lead to resource shortages which undermine the ability to provide continuous, personalized care. Subdivisions (c)(1)(A) through (c)(1)(C) clearly outline those specific cases of emergencies with examples from Federal Emergency Management Agency (FEMA).¹⁹

Adopt subdivision (c)(2). This proposed regulation provides specific examples of a shortage of equipment and/or supplies to clarify what the Department would consider as limited resources and capacity.

Adopt subdivisions (c)(3) through (c)(3)(A)(iii) to further specify HSC section 1748(f)(2). The Department finds it reasonable to state that a hospice which is unable to finance the agency’s operation longer than 90 days can and should be considered

¹⁹ Federal Emergency Management Agency, Emergency Management Institute, “IS-111.A: Livestock in Disasters. *Emergency Management in United States.*” Retrieved on 02/25/2025,

evidence of long-term financial instability. Financial institution statements and cost reports are valuable documents that can provide a detailed overview of the applicant's financial condition, which are therefore necessary to submit as proof of financial hardship. For more information on unmet need, please refer to section 74820(e).

Subdivisions (d)–(h) authorize the Department to request additional information, clarify the five-year prohibition reset, allow exceptions for extenuating circumstances, and require continuous operation until CHOW approval to protect patient safety.

Adopt subdivision (d) for the same reason as section 74812(g). To ensure that an applicant is properly evaluated for change of ownership application. While the majority of the requirements listed in this section and in section 74812 (content of application) should be sufficient to assess the applicant's qualifications, there may be instances where the Department requires additional information for a more comprehensive evaluation, ensuring all criteria for licensure are met and the applicant is thoroughly vetted. HSC section 1748(b) gives the Department authority to request additional information the Department believes necessary to fully evaluate an applicant. Also, there are times where there is simply an oversight of information from the applicant. In these situations, the Department currently allows 60 days for the applicant to remedy this oversight and adhere to the Department's request. Along with ensuring proper evaluation of an applicant, this regulation is necessary to align with Department's current practice and establish transparency within Title 22 regulations.

Adopt subdivision (e) to further clarify and make specific HSC section 1748(e). The statute prevents a licensee from changing ownership within the first five years of operation. This regulation further specifies that the clock will be reset if a new licensee takes over the hospice. This regulation clarifies that the five-year CHOW prohibition does not apply just once but rather every time there is a CHOW, ensuring better clarity for those regulated.

Adopt subdivision (f). Stakeholders commented that the 120-day application submission timeframe specified in subdivision (b) is reasonable as long as it comes with a condition to waive the timeframe in extenuating circumstances. For example, it would be impossible to always anticipate the death of an owner that would result in a necessary change 120 days in advance. Similar to subdivision (c), the Department is proposing this exception language to give flexibility to what is required in subdivision (b).

Adopt subdivision (f)(1) because a receivership order cannot always be anticipated 120 days in advance. While it is possible in some cases to predict financial distress or signs that a hospice may enter receivership, some factors causing it can be unpredictable such as economic downturns or legal challenges. The Department therefore proposes that as long as the licensee can prove they have a receivership order, it is eligible for an exemption from the 120-day application submission timeframe.

Adoption subdivision (f)(2). As mentioned above, a death cannot be predicted 120 days in advance. Therefore, the Department is willing to accept the current licensee's death certificate as valid proof and qualification for an exemption.

Adoption subdivisions (f)(3) and (f)(4) for the reasons outlined in subdivisions (c)(1) and (c)(3).

Adopt subdivisions (g), (g)(1) and (g)(2) outlining and clarifying the two situations when a CHOW application does not need to meet the unmet need requirement of this chapter. The two requirements listed are in alignment with current industry practice under HSC section 1749(f)(2)(A) and are reasonable because the previous owner had already met all qualifications and proven a need for services in the area. Asking the prospective new owner to re-qualify for unmet need for the same location would be unnecessary because the "need" is based on and determined by the hospice agency's location regardless of who the owner is. This regulation is necessary to protect currently established hospice agencies and prevent unnecessary hospice closures due to the new unmet need requirement.

Adopt subdivision (h). Preventing relinquishment of a current licensee until the prospective new licensee is fully vetted and the CHOW is approved is necessary for the health and safety of patients. This ensures that the hospice can operate without interruption and helps to ensure unauthorized individuals do not operate a hospice and gain access to private patient medical record information or other sensitive hospice information.

Adopt section 74828 "Report of Changes."

Section 74828 establishes requirements for reporting changes that affect hospice operations or licensure, ensuring compliance and continuity of care. This section effectuates Health and Safety Code section 1753.1(f). Hospice agencies are required to report changes that necessitate an updated license, such as change of location, name, and services offered in addition to other changes that do not impact the license but still need to be reported to the Department. The Report of Changes (ROC) process serves as a method for regulating hospice agencies when there is a significant change that impacts the operation or records of the hospice. Similar to the initial licensure process, the ROC process uses the HS 200 series mentioned in the Content of Application section. The Department is proposing to adopt this section to specify requirements for each type of ROC, ensuring the regulated community is clear on what is needed during the ROC process. All provisions in this section are necessary to be adopted in Title 22 regulations to align with current practices enforced by the Department. Many of the requirements are also necessary for Department's surveying purposes. Adopting this section also ensures standardization and consistency throughout the Title 22 health facilities application process.

The Content of Application section provides a comprehensive list of full requirements that must be met for initial licensing or changes of ownership application. Unlike initial licensure, the ROC process applies only to changes requiring Department review,

ensuring efficiency and regulatory compliance. Since not all changes require a full application process, like the initial license, the ROC section selectively draws items specified in the Content of Application section, applying only the ones that are necessary for the particular type of change being reported. The ROC process is more efficient by focusing only on the elements that directly impact the specific change being made, rather than requiring the full set of documentation needed for the changes. Adopting this section is necessary to provide convenience to applicants, ensuring the right requirements are provided without unnecessary complications.

Adopt subdivision (a). Subdivision (a) clarifies that all ROC processes require an application, not just a notice, to ensure proper review and record-keeping. This fundamental language clarifies that every ROC process requires an application, so hospice agencies should not be confused and send a notice instead of submitting an application. As stated in section 74812(b), requiring a cover letter with information will create efficiency because it clarifies the overall intention and the purpose of the application. The cover letter also helps to immediately highlight key information about the applicant, making it more convenient to identify during the application review process.

Adopt subdivision (a)(1). Subdivision (a)(1) requires submission of ROC applications for significant changes, such as ownership or service area, at least 120 days in advance. This timeframe allows thorough review and prevents unauthorized changes. Along with the change of ownership mentioned in section 74824, the Department clarifies that the licensee must submit change of geographic service area, indirect ownership, and a transfer of beneficial ownership application 120 days in advance because these ROCs significantly impact the operation of the hospice agency. The 120-day limit was chosen because it gives the Department ample time to thoroughly review these changes to ensure they are valid and in compliance with the requirements of this chapter. Subdivisions (a)(1)(A)–(a)(2)(C)(iii) identify documentation required for changes in service area, location, or ownership, and provide exemptions for emergencies such as lease cancellations or natural disasters to ensure continuity of care.

Adopt subdivision (a)(1)(A) identifying which specific parts of the hospice application must be completed for any proposed change to a hospice agency's geographic service area. The identified subdivisions from section 74812 are the ones most relevant to service areas and therefore necessary for the Department to process a service area ROC application. This proposed regulation helps to provide convenience to applicants by making the requirements easily identifiable streamlining the ROC application process without unnecessary complications.

Adopt subdivision (a)(1)(B) for the same reasons described in subdivision (a)(1)(A) above.

Adopt subdivision (a)(1)(B)(ii) for convenience to applicants. Clearly identifying all Medicare and Medi-Cal related subdivisions for applicants makes the requirements

easily identifiable and streamlines the ROC application process without unnecessary complications.

Adopt subdivision (a)(2) to fully effectuate the requirement of HSC section 1753.1(f). A 60-day notice is reasonable and necessary because the changes listed pertain to time-sensitive information that is critical for proper identification and record-keeping, however not as time-sensitive as the changes under (a)(1). The identified ROCs impact the hospice license because this information needs to be accurately displayed in the hospice office space, therefore sufficient time to record the change and issue an updated license is warranted.

If a proposed Change of Location (CHOL) will result in the hospice agency operating under a new GSA, the hospice must submit all necessary documentation under section 74812(c)(1) and meet all requirements of section 74820. Even though the hospice is currently active and operating, it is only approved to do so in its current GSA and would be considered a “new hospice” under any other GSA and is required to meet all necessary criteria. A hospice agency cannot simply move to and continue to operate under a new GSA unless the new GSA has a need for more hospice agencies and the hospice receives approval from the Department.

Adopt subdivisions (a)(2)(A), (a)(2)(A)(i) and (a)(2)(A)(ii) for convenience to applicants. Clearly identifying all Medicare and Medi-Cal related requirements from the hospice application as they relate to a change of location or change of services helps streamline the ROC application process without unnecessary complications.

Adopt subdivision (a)(2)(B) to remain in alignment with the GSA requirements from the hospice license application. A hospice agency that changes its location will need to submit the same documentation for review as it did during the initial licensure application process for the Department to be able to appropriately review. This proposed regulation is necessary because it clearly and conveniently identifies all GSA related subdivisions that must be submitted streamlining the ROC application process without unnecessary complications.

Adopt subdivision (a)(2)(B)(i) to remain aligned with the requirements of section 74820 (Geographic Service Area). This proposed regulation is necessary to remind applicants that the agency’s new location will be re-evaluated and must be able to adhere to the 2-hour travel limitation to be approved by the Department.

Adopt subdivision (a)(2)(B)(ii) for the same reason outlined in subdivision (a)(2). A currently licensed hospice agency cannot simply move to a new GSA and continue operating unless that new GSA has a need for more hospice agencies and the hospice receives approval from the Department. This is only required for any newly added counties and does not affect the hospice’s ability to operate in its currently approved counties.

Adopt subdivision (a)(2)(B)(iii) to ensure that all hospice agencies have an established place of business that meets the requirements of section 74908 (Hospice Office Space). This is necessary to meet the intent of HSC section 1753.1(e) and combat fraudulent activity in the industry. A legitimate and well-established office is a basic necessity to operate a hospice agency.

Adopt subdivision (a)(2)(C) detailing the possible situations a hospice agency may not be able to meet the 60-day notice requirement for CHOL application. Stakeholders were generally supportive of the 60-day notice requirement but raised valid concerns that there may be instances where an exemption may be required. This regulation is necessary to address those concerns and provide clarity/transparency to the regulated community.

Adopt subdivision (a)(2)(C)(i). A sudden and unexpected cancellation of a lease is a valid reason for an exemption to the 60-day requirement. The hospice and/or licensee cannot reasonably give advance notice to the Department if they were not given adequate notice themselves.

Adopt subdivision (a)(2)(C)(i)(ii). Sudden and unexpected damage to the hospice agency's office that disrupts operation is a valid reason for an exemption from the 60-day requirement. If a hospice agency is unable to properly operate and needs to quickly move to a new office location, this is reasonable and necessary to resume operation as quickly as possible to protect the health and safety of patients.

Adopt subdivision (a)(2)(C)(iii) for the same reasons outlined in section 74824 (Change of Ownership) subdivisions (c)(1) and (c)(1)(A) through (c)(1)(C). A hospice cannot reasonably give the Department 60-day advance notice of a CHOL in unexpected and/or sudden emergency situations such as natural disasters (floods, fires, earthquakes, etc.), pandemics, or other large-scale crises therefore an exemption in these instances would be necessary and valid.

Subdivisions (b)–(e) require timely reporting of changes in management, governing body, and program participation, with clear documentation requirements to protect patient safety and maintain accurate records.

Adopt subdivision (b). A change of hospice management personnel is a ROC that the Department must be made aware of to be able to properly vet the newly appointed individual. While this is not the most impactful ROC situation, it is necessary for the Department to ensure the new individuals meet all required qualifications to protect the health and safety of patients. This regulation is necessary to clarify the exact information/documentation from section 74812 (Content of Application) that is pertinent and must be included in the ROC application. The 10-business day notice requirement is current standard practice pursuant to HSC section 1749(b)(3).

Adopt subdivision (c). A hospice agency's participation in the Medicare or Medi-Cal programs is a significant ROC that must be timely and accurately reported to the

Department pursuant to HSC section 1749(a)(4). This regulation is necessary to clarify the exact information/documentation from section 74812 (Content of Application) that is pertinent and must be included in the ROC application. The 10-day notice requirement is also current standard practice under HSC section 1749(a)(4).

Adopt subdivision (d). A change to the hospice's governing body or principal officers is a significant ROC that must be reported for the same reasons outlined above in subdivision (c).

Adopt subdivision (d)(1). This documentation is necessary to thoroughly review the ROC application and properly review and record the change to the hospice governing body or principal officers of the governing body.

Adopt subdivision (d)(2). The same reasons outlined for adopting section 74812 (Content of Application) subdivisions (c)(33) and (c)(34) apply here.

Adopt subdivisions (e), (e)(1), and (e)(1)(A) through (e)(1)(C). This regulation is necessary for the Department to fully implement the statutory requirement of HSC section 1753.1(f). While these ROCs are not the most impactful to the operation of the hospice, it is critical for the Department to be notified to ensure accurate identification and record-keeping. This regulation is necessary to clarify the exact information/documentation from section 74812 (Content of Application) that is pertinent and must be included in the ROC application. It is reasonable and appropriate to implement the same 10 business day notice requirement for consistency purposes.

Subdivisions (f)–(i) clarify approval requirements for significant changes, mandate signatures for enforceability, and set a 30-day timeframe for additional documentation to expedite ROC processing.

Adopt subdivisions (f) and (f)(1) through (f)(6) outlining the most impactful ROCs and clarifying that these types of changes require Department approval prior to implementation. This is necessary to guarantee that all criteria and requirements pursuant to this chapter are met and properly adhered to.

Adopt subdivision (g) because a signature and date from the applicant are necessary to ensure that the application is legally binding and enforceable.

Adopt subdivisions (g)(1) and (g)(1)(A) through (g)(1)(C) for the same reasons identified in section 74812 (Content of Application) subdivision (e).

Adopt subdivisions (g)(2) and (g)(2)(A) through (g)(2)(C). The basic execution of signing usually involves a legal name, date, and a job title. The Department is accepting an authorized signatory as a signer to provide flexibility to the applicant when they are unable to sign and date a ROC application due to unforeseen circumstances. A photo ID is required to confirm the legitimacy of the authorized signatory.

Adopt subdivision (h). Requiring an applicant to retain a copy of the application package ensures access to records for future reference, if needed.

Adopt subdivision (i) for the same reasons identified in section 74812 (Content of Application) subdivision (g). The Department must be able to do its due diligence to ensure that all ROC applications are properly evaluated. However, the Department proposes a 30-day requirement to submit the requested information for ROC applications, instead of the standard 60-day timeframe for initial licensure applications. ROC applications are typically more straightforward than initial applications and should be able to be reviewed and approved in a quicker manner, therefore it is better not to delay the process for any additional documentation needing to be submitted in 30 days.

Adopt section 74832 “Denial of Application.”

Section 74832 establishes standards for denying hospice licensure applications to address oversight issues identified in the Audit Report and protect patient safety. This section effectuates Health and Safety Code sections 1749(f)(1), 1751.5(a)(3), and 1755(a)(7). Section 74832 was developed to address many of the licensure oversight issues identified in the Audit Report and is necessary to give Department surveyors the tools to properly enforce the requirements of this Chapter and protect the health and safety of hospice patients.

Adopt subdivision (a). Subdivision (a) lists reasons for denial, providing transparency and ensuring only qualified applicants operate hospices. This subsection is necessary to clearly identify the various reasons the Department may deny a hospice licensure application. This is necessary to establish full transparency for the regulated community.

Adopt subdivision (a)(1). This requirement establishes that failure to meet all requirements under this chapter or applicable statutes warrants denial to protect patient safety. This is necessary because failing to meet all requirements under this chapter, as well as the hospice requirements under HSC as referenced in the text, is a clear indication that the applicant is not yet prepared to fully and properly operate a hospice agency. Approving an application that does not meet the basic requirements would pose a risk to the health and safety of hospice patients.

Adopt subdivision (a)(2). This requirement establishes that failure to meet Medicare CoPs under Title 42 CFR justifies denial to prevent harm to patients. This is necessary for the same reasons as subdivision (a)(1) above. If an applicant elects to participate in the Medicare program but fails to meet the CoPs outlined in Title 42 Code of Federal Regulations as referenced in the text, that could also result in serious harm to patients. The CFR CoPs, in conjunction with the new regulations proposed under Title 22, are designed to establish safety and care standards for all Medicare participants receiving care in California; failure by a hospice to meet all such requirements fully justifies the Department’s denial of that agency’s request for licensure.

Adopt subdivision (a)(3). This requirement establishes that failure to implement an approved plan of correction under section 74904 poses risks and warrants denial. This

is necessary to fully effectuate section 74904 (Plan of Correction) which specifically identifies what hospice agencies need to do to return a completed and acceptable plan of correction to the Department. If a hospice agency fails to fully implement all elements of the plan of correction as proposed, this puts the health and safety of hospice patients at risk because that means one of the issues/concerns identified by Department surveyors as being potentially harmful to patients is not being corrected and the facility would remain out of compliance.

Adopt subdivision (a)(4). This requirement establishes that applicants with recent license revocation or suspension must wait 24 months before reapplying, consistent with HSC section 74671(b)(2). This is necessary because an applicant with recent history of non-compliance that resulted in the Department suspending or revoking their previous license potentially poses a risk to patients. Waiting at least 24 months to grant the applicant licensure again allows the individual time to make necessary adjustments to avoid similar enforcement actions. This 24-month waiting period also aligns with similar Title 22 facility types such as HHA regulations under HSC section 74671(b)(2).

Adopt subdivision (a)(5). This requirement establishes that applicants that fail to submit a complete application or remediate all discrepancies in an application in response to the Department's request to provide additional information will be denied. This is necessary because all the application information is required for the Department to determine whether the applicant is qualified and prepared to operate a hospice agency. The Department has a duty to thoroughly review an applicant's information to determine whether the applicant is reputable and responsible to operate an agency in compliance with licensing requirements to limit risks to the health and safety of patients.

Adopt subdivision (a)(6). This requirement establishes that applications proposing service areas without unmet need under section 74820 will be denied to prevent clustering and potential fraud. This is necessary to fully effectuate the requirements of HSC sections 1749(f)(1) and 1751.5(a)(3). Clustering of hospice agencies in metropolitan areas raises concerns about potentially fraudulent activity. In response to the Audit Report and the legislative mandate under HSC section 1753.1, the Department developed section 74820 (Geographic Service Area). The Department wrote 74820(e) to align with HSC 1749(f)(1) by reiterating for consistency that a hospice's GSA can only include counties that have an unmet need for hospice services. For additional clarity to the regulated community, 74820(e) directs the reader to the definition of "unmet need" in Article 1. Section 74820 subdivision (f) outlines a step-by-step formula for how an unmet need for hospice services must be calculated and determined for every county. If a hospice licensure application proposes to service a GSA that does not meet the requirements of section 74820 subdivisions (e) and (f), the Department would be justified in denying the application because the proposed county does not have a need for additional hospice services. This regulation is necessary to combat clustering and overconcentration of hospice agencies in a community.

Adopt subdivision (a)(7). Licensing fees are a common industry practice that are required under HSC section 1266 in conjunction with submission of an application

pursuant to section 74816 (Licensing Fees). The licensing fee is collected to recoup the cost to the State of operating the licensing program. If a hospice agency has unpaid fees, then the Department considers the application to be incomplete and would not be able to grant licensure to this applicant until the required fees have been paid.

Adopt subdivision (a)(8). This requirement establishes that applicants with inactive Secretary of State or Franchise Tax Board status cannot be licensed, consistent with Title 2 CCR section 21001 and Revenue and Taxation Code (RTC) sections 23301 and 23775. This is necessary because it reflects the current practice for any business established in the State of California. Business entities in California are required to register with the Secretary of State (SOS).²⁰ Section 21001 of Title 2 of the California Code of Regulations sets standards on which business structures are considered entities in California (corporations, limited liability companies, and limited partnerships), and the meaning of an active status. One of the most common inactive statuses for a business entity is “SOS/FTB Suspended or Forfeited.” A business entity can be labeled with this status if the entity does not file a statement of information with the SOS annually/biennially, and/or if the entity is delinquent on tax activities with the Franchise Tax Board (FTB). Pursuant to section 233301 of the RTC, suspended/forfeited businesses do not have rights and privileges to exercise its business entity power and cannot conduct nor transact business in the State of California. Pursuant to RTC section 23775, if the business entity is a tax-exempt organization, FTB also may revoke the tax-exempt status. FTB notifies the SOS and provides updates on suspensions so SOS can publicly display the suspension status. The Department cannot grant and/or renew a license to an applicant with an SOS/FTB inactive status because the licensee is no longer considered a valid business entity.

Additionally, current practice requires a licensee/business entity to provide evidence of active status to the Department every time an initial licensure, change of ownership, or license renewal application is submitted and the Department will use the SOS website to verify the business entity status of the licensee.²¹ The adoption of this regulation enhances the legitimacy of licensing policies and procedures, is necessary to align with current practice, and is necessary to ensure that hospice licensure is only granted to fully-compliant and responsible applicants for the health and safety of patients.

Adopt subdivision (a)(9). This requirement establishes that providing false information under penalty of perjury warrants denial, consistent with HSC section 1755(a)(7). This is necessary for the same reasons identified in subdivision (a)(5). Applicants sign the application under penalty of perjury that the information being provided is correct to the best of their knowledge. Providing inaccurate information on a State application

²⁰ CA Office of the Small Business Advocate, “*Choose a Business Structure and Register Your Business*”, Last Accessed February 4, 2025, <https://calosba.ca.gov/business-learning-center/start-up/choose-a-business-structure-and-register-your-business/>.

²¹ CA Secretary of State, “*Business Search*”, Last accessed February 4, 2025, <https://bizfileonline.sos.ca.gov/search/business>.

demonstrates a lack of compliance with requirements and warrants license denial, suspension, or revocation. This regulation is in alignment with current statute under HSC section 1755(a)(7).

The above requirements are necessary to provide the regulated community with full transparency regarding actions that would cause the Department to deny an application. These regulations are necessary to protect the health and safety of hospice patients by ensuring only qualified and compliant prospective licensees are allowed to open and operate a hospice agency in the State of California.

Adopt subdivision (b). Subdivision (b) prohibits employment of management personnel with disciplinary actions within seven years, consistent with Business and Professions Code (BPC) section 480(a)(1), to protect patient safety. This regulation was derived from the current statute under BPC section 480(a)(1), which states the following:

[A] board may deny a license regulated by this code on the grounds that the applicant has been convicted of a crime within the preceding seven years from the date of application... .

While BPC 480(a)(1) only directly addresses an “applicant,” this language is appropriate to apply to hospice management personnel. Hospice management personnel have a significant effect on the day-to-day operations of a hospice. Prohibiting individuals who have recent disciplinary actions against their professional license from filling these roles within a hospice agency protects the health and safety of patients. The Department is aligning with the 7-year limitation under BPC for consistency with professional standards. Any hospice licensure application that proposes to employ a manager that has had disciplinary action against their professional license within the 7-year period prior to submitting the application may be denied. The Department will notify the applicant of the need to replace the problematic manager and request that they find another manager that is qualified and eligible to serve in that role. The Department is aware that simply denying the application without providing an opportunity to correct the issue would pose a financial burden on the applicant because fees are non-refundable. If the applicant refuses or does not successfully replace the identified individual in a reasonable amount of time the Department will deny application to protect the health and safety of patients.

Subdivisions (b)(1)–(b)(7) list disqualifying activities, including fraud, abuse, and unethical conduct, to ensure only qualified individuals manage hospice operations.

Adopt subdivisions (b)(1) through (b)(7) which provide examples of activities that warrant disciplinary action against a hospice management personnel member. These examples are necessary to provide clarity to the regulated community regarding the type of activities that would disqualify someone from serving in a hospice management position, including examples of fraudulent and abusive behaviors that would pose a health and safety risk to vulnerable and dependent hospice patients.

Adopt subdivision (c). Subdivision (c) clarifies an applicant's right to appeal a denial within 15 days, consistent with Health and Safety Code section 1755(b) and Government Code section 11506. HSC section 1755(b) references Government Code (Gov) section 11506 which discusses a respondent having 15 days to file a response with the agency to challenge the notice of a reduction in force which is rights to appeal language. This regulation is necessary to ensure the regulated community is aware of the rights granted to them and to maintain a fair and equitable licensure process.

Adopt section 74836 “Renewal and Expiration.”

Section 74836 establishes renewal and expiration requirements to clarify licensee responsibilities and prevent lapses in compliance. This section is necessary to establish standard industry practice that mirrors the requirements found on the license renewal application. This information must be formally addressed in the regulations for clarification to the regulated community. This section effectuates Health and Safety Code sections 1751(b) and 74671(d).

Adopt subdivision (a). Subdivision (a) clarifies that licensees are responsible for timely renewal, even if the Department does not issue a notice, to ensure continuous compliance and avoid penalties. This is necessary because licensees tend to assume that if the Department does not send a renewal notice to the licensee, the licensee does not bear responsibility for timely renewal. This regulation clarifies that licensees are fully responsible for complying with license renewal requirements and that the licensee is still obligated to request and submit a timely renewal application even if the Department does not provide notice of renewal. This language is also consistent with HHA licensure as seen under HSC section 74671(d). This regulation is also necessary to clarify the definition of “license renewal application” for the regulated community and to reinforce the license renewal timeline specified in HSC section 1751(b). Having all this information together benefits the regulated community so that they know what is expected of them and the timelines for renewal to avoid late payment penalties which will be assessed if they fail to renew timely.

Adopt subdivision (b). Subdivision (b) specifies the steps required to submit a complete renewal application, ensuring accuracy and compliance. This is necessary to clearly outline the required steps a licensee must complete to properly submit a hospice renewal application.

Adopt subdivision (b)(1). Subdivision (b)(1) requires submission of a renewal application with all required fees, consistent with sections 74812 and 74816. The renewal application must be received at least 30 days before license expiration to prevent a lapse in licensure. This is the necessary first step of receiving a hospice licensure renewal, which is to complete and submit a renewal application with the required fees. Please refer to section 74812 (Content of Application) and section 74816 (Licensing Fees) for further justification of the need for these basic elements.

This regulation also clarifies that a renewal application must be received 30 days prior to expiration of the current license, which is necessary to ensure a timely and streamlined process. The 30-day timeline is again consistent with HHA regulations under HSC section 74671(d) which ensures the Department has enough time to review and approve the application and prevent hospice agencies from potentially operating under an expired license.

Subdivisions (b)(2)–(b)(5) require reporting of changes, signatures for enforceability, acknowledgment of compliance, and verification of active business entity status to ensure accurate records and prevent fraudulent activity.

Adopt subdivision (b)(2). Subdivision (b)(2) is intended to ensure that all licensure documentation submitted to the Department is accurate. To this end, this subdivision requires that any inaccuracies in the information on the Department’s renewal verification page be updated by the licensee. The Department has determined that the responsibility to identify and revise such licensure documentation is best placed on the licensee as they are best positioned to assess their own information. Assigning responsibility to the licensee for maintaining their licensure documentation is also more efficient, as it may eliminate delays that could occur if the Department were to review and verify all license documentation. This approach is expected to both streamline the process and improve the accuracy of existing licenses.

Adopt subdivision (b)(3). A signature and date from the applicant are necessary to ensure that the application is legally binding and enforceable. The basic execution of signing usually involves a legal name, date, and a job title. This regulation is necessary to clarify that if any listed information is incorrect, it is the responsibility of the signee to prove a ROC application was submitted to make the necessary update.

Adopt subdivision (b)(3)(A) which is necessary to ensure that the individuals within the hospice that are responsible for the administrative management of the agency are involved in the renewal process and have the final opportunity to “sign-off” on the validity of the application. Limiting the signature to only either the licensee/owner or the hospice Administrator will ultimately help protect the health and safety of patients.

Adopt subdivision (b)(3)(B) identifying all acknowledgments that are confirmed upon signature.

Adopt subdivision (b)(3)(B)(i) because the Department cannot renew a hospice’s license until all necessary fees are paid. For further justification, please see section 74816 (Licensing Fees) and section 74832 (Denial of Application).

Adopt subdivisions (b)(3)(B)(ii) and (b)(3)(B)(iii) to align with current standard practice. Reportable changes are sometimes displayed on the license, such as licensee/facility name, location, and types of services. If a hospice does not report such changes, the information displayed on the renewed license will be inaccurate and will not comply with state regulations specifically section 74828 (Report of Changes). This

regulation is necessary to enforce a valid and accurate license renewal process for every licensee.

Adopt subdivisions (b)(3)(B)(iv) through (b)(3)(B)(vi) for the same reasons discussed in section 74812 (Content of Application) subdivision (e).

Adopt subdivision (b)(4). Submitting accurate and current information on an application is necessary to ensure the hospice record is up to date, and to ensure important communication is timely received. It is reasonable for the Department to request basic current contact information such as email, phone number, etc. for communication purposes.

Adopt subdivision (b)(5) which is necessary to align with current practice which requires applicants to provide evidence of an active business entity status with the SOS in order to be eligible for licensure. An SOS entity number is the State equivalent of an employer's tax ID number, and the Department uses the SOS business entity search to verify the status of every applicant's SOS entity number. For further justification, please refer to section 74832 (Denial of Application) subdivision (a)(8).

Adopt section 74840 "Voluntary Cancellation of License."

Section 74840 establishes requirements for voluntary license cancellation to ensure patient safety and continuity of care during hospice closure. Section 74840 is necessary to outline the basic information and instructions a hospice agency would need to properly close its business without putting the health and safety of its patients at risk.

Adopt subdivision (a). Subdivision (a) requires licensees to notify the Department at least 60 days before closure, consistent with Title 42 CFR section 489.52(a)(2), to allow sufficient time for oversight and patient transition. Due to the lack of clarity in the hospice licensure act regarding the timeframe for hospice closure notice, the Department followed an example set forth in Title 42 CFR section 489.52(a)(2) which contains a 60-day timeframe for voluntary termination notification for skilled nursing facilities (SNFs). SNFs are a closely related facility type; therefore, the Department determined that a 60-day timeframe would also be reasonable for hospice agencies.

Adopt subdivision (a)(1) which is basic necessary information that the Department would need to contact the licensee for any additional information, general questions or issues.

Adopt subdivision (a)(2) to accurately identify the hospice in its Electronic Licensing Management System (ELMS). This is necessary to ensure the Department processes and records the closure of the correct hospice agency license.

Adopt subdivision (a)(3). It is reasonable for the Department to know the reason the hospice is closing. For example, if the reason is due to financial difficulty, this could impact care to hospice patients during the transition period. This regulation is necessary because the closure date is vital for the Department to be able to accurately process

and record the closure request. Adding this regulation ensures accurate records management and aligns with departmental practice.

Adopt subdivision (a)(4) to make the closure agreement enforceable and legally binding.

Adopt subdivision (b). Subdivision (b) requires notification to oversight entities, including CMS and accreditation organizations, to ensure compliance and accurate record-keeping.

Adopt subdivision (b)(1) to ensure CMS receives closure notification pursuant to Title 42 CFR section 489.52(a)(1). Most hospices are federally certified to receive reimbursement from Medicare, Medi-Cal, or both. Under current practice the Department does not finalize license cancellation until the hospice is decertified. This regulation is necessary to ensure all involved parties are aware of the closure, and to align with the current practice.

Adopt subdivision (b)(2) to ensure that if a hospice accreditation organization was involved with the licensing and certification of the hospice that intends to close, that the appropriate organization is notified and made aware for accurate record-keeping.

Adopt subdivision (c). Subdivision (c) requires licensees to notify patients and families of closure and provide discharge instructions, consistent with section 74892(w), to ensure continuity of care and protect patient dignity. This is necessary to protect the health and safety of patients. The licensee must properly notify existing patients of the anticipated closure to ensure those patients, and their families have sufficient time to make appropriate alternative arrangements. To provide ample clarity to the regulated community, the Department identified all necessary information that must be included in a discharge statement to patients which can be found in section 74892 (Medical Record Content) subdivision (w). This regulation is necessary to ensure licensees do not leave vulnerable hospice patients in a position where they suddenly do not have the care or services they need to maintain their dignity during the dying process.

Adopt section 74844 “Involuntary License Suspension, Revocation, and Reinstatement.”

Section 74844 establishes standards for suspension, revocation, and reinstatement of hospice licenses to ensure compliance and protect patient safety, consistent with Health and Safety Code section 1755. This is necessary to codify industry standard practices that are necessary to ensure only qualified and compliant hospice agencies are able to maintain licensure. This is necessary to ensure the Department retains its ability to impose sanctions (such as disciplinary action) on noncompliant hospice agencies to maintain accountability, protect public trust, and ensure continued compliance with established standards and regulations.

Adopt subdivision (a). Subdivision (a) specifies grounds for suspension or revocation to ensure accountability and transparency in enforcement. This is necessary to provide

the regulated community with clarity and full transparency on grounds for suspension or revocation of a license.

Subdivisions (a)(1)–(a)(6) align with section 74832 (Denial of Application) and authorize disciplinary action for failure to meet requirements, failure to implement corrective plans, unapproved operational changes, unpaid fees, operating without a license, or providing false information.

Adopt subdivision (a)(1) for the same reasons identified in section 74832 (Denial of Application) subdivision (a)(1).

Adopt subdivision (a)(2) for the same reasons identified in section 74832 (Denial of Application) subdivision (a)(3).

Adopt subdivision (a)(3). Specific reportable changes outlined in section 74828 (Report of Changes) must be reviewed and approved by the Department for appropriateness, therefore it is reasonable to suspend or revoke a hospice's license if they are operating under different circumstances than when licensure was granted.

Adopt subdivision (a)(4) for the same reasons identified in section 74832 (Denial of Application) subdivision (a)(7).

Adopt subdivision (a)(5). It is reasonable and necessary for the Department to take disciplinary action against a hospice agency that is operating without an active license to protect the health and safety of patients. Such an agency has not demonstrated compliance with all state and federal regulations necessary to be granted licensure.

Adopt subdivision (a)(6) for the same reasons identified in section 74832 (Denial of Application) subdivision (a)(9).

Adopt subdivision (b). Subdivision (b) establishes a 15-day timeline for appeals, consistent with Health and Safety Code section 1755 and Government Code section 11506, to ensure due process and transparency. This is necessary for the same reasons identified in section 74832 (Denial of Application) subdivision (c). The 15-day timeline follows the direction found under HSC section 1755 which then points to a clear 15-day requirement under Gov Code section 11506. This is necessary to ensure transparency among the regulated community and help maintain/uphold the rights of licensees.

Adopt subdivision (c). Subdivision (c) affirms the Department's authority to impose sanctions for noncompliance, consistent with Title 22 CCR section 70135(e). This is necessary to establish standard industry practice and to align with other Title 22 facility types. (See, e.g., GACH regulations under Title 22 CCR section 70135(e), for example.) This regulation is necessary to ensure the Department retains the ability to protect the public and hold hospice agencies accountable for noncompliance.

Adopt subdivisions (d), (d)(1), and (d)(2). Subdivisions (d)(1)–(d)(2) require submission of all application content for reinstatement and impose a one-year waiting period, consistent with Title 22 CCR section 74687, to ensure corrective action and compliance before re-licensure. This is necessary to establish the conditions for reinstatement. It is reasonable and necessary for a hospice agency to re-submit all content of application information required under section 74812 because the hospice agency lost its prior license and is requesting a new hospice license. The Department must be able to review and ensure the hospice agency meets all current requirements of this chapter. Additionally, the one-year waiting period is consistent with HHA regulations under Title 22 CCR section 74687 and necessary to ensure the hospice has had sufficient time to correct any issues that affected its ability to maintain its prior license. After meeting all necessary reinstatement requirements as outlined above, it is then reasonable for the Department to give a hospice agency another chance to obtain licensure and provide services to patients again. This will help to build and maintain trust between the Department and the regulated community.

ADOPT ARTICLE 3 “SERVICES”

Adopt Section 74848 “Nursing.”

Section 74848 establishes nursing service requirements, including nurse-to-patient ratios, to ensure quality care and compliance with Health and Safety Code section 1753.1(b). The Audit Report noted the lack of hospice nurse to patient ratio as an area of concern in the Department’s current licensing authority. Subsequently, the Department became legislatively mandated under HSC section 1753.1(b) to set a standard for determining an appropriate nurse to patient ratio.²² There are not currently nurse to patient ratios in the federal CoPs under Title 42 CFR, the 2005 CHAPCA Standards, or other similar Title 22 facility types.²³ Additionally, the Department did not find any hospice nurse to patient ratios in the regulations of any other state. This section sets enforceable standards for patient safety.

Adopt subdivision (a). Subdivision (a) requires nursing services to be available 24/7 to ensure timely care for patients experiencing end-of-life symptoms, consistent with HSC section 1749(d)(1) and CMS CoPs. This is necessary to establish that nursing services must be available at all times which is necessary to ensure that patients who are experiencing end of life pain and suffering have access to care at any time of day, as necessary. This requirement is in line with HSC section 1749(d)(1), the 2005 CHAPCA Standards, and CMS CoPs for hospice. It was also necessary to clarify the meaning and usage of “licensed nurse” and “assigned” within this section to avoid any confusion among the regulated community.

²² Audit Report at pg. 32.

²³ California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivision (b). Subdivision (b) limits nurse caseloads to 12 patients to ensure quality care and prevent staff burnout, based on stakeholder input and industry research. This is necessary to effectuate HSC section 1753.1(b) and to establish a new standard and clarify to the regulated community that hospice nurses cannot have more than 12 patients at any one time. As previously mentioned, these standards are currently non-existent within the hospice industry, therefore the Department did extensive research attempting to determine and establish an appropriate ratio.

As a starting point for development, the Department considered a 2022 study from the Berry Dunn Organization which reported that the average caseload per registered nurse (RN) case manager was 13-18 patients.²⁴ The Department used this information as its basis for further research and discussions. During drafting of these regulations, the Department held three stakeholder engagement meetings to get input and suggestions from the regulated community on what a reasonable and acceptable standard and ratio should be, and in one meeting specifically suggested a ratio of 1:15 which is the average of the 2022 Berry Dunn study results. The feedback received was generally accepting of a 1:15 ratio, however a considerable number of comments were received from stakeholders recommending 1:12 instead to make sure nurses are able to spend ample time with patients and provide quality care and to help avoid “burnout” in the midst of a nursing shortage. After the November 8, 2023 stakeholder engagement meeting, CHAPCA submitted to the Department a 2016 National Hospice and Palliative Care Organization (NHPCO) staffing guidelines report that includes 2014 census data, and similarly shows a 1:12 median patient case load for RN case managers.²⁵ Secondly, a separate NHPCO report shows that the ratio has historically been an average of 12 patients per nurse “as recent as the first quarter of 2021”.²⁶ And lastly, while there is very little medical literature available regarding this topic, a 2022 Hospice News article states that “historically, caseloads for hospice nurse case managers have hovered around 10 to 12 patients” which is also in alignment with previous findings.²⁷

After careful consideration from all available resources, and input from stakeholders and subject matter experts, the Department concluded 12 patients per nurse to be the most appropriate ratio. This proposed regulation is necessary to ensure patient receive quality and timely care during the last stages of their lives while also protecting the well-

²⁴ Lindsay Doak, Director of Research, BerryDunn. “*Preparing for the Evolving Healthcare Environment, Insights from the Healthcare at Home National Best Practices and Future Insights Study*,” Last accessed on 11/01/2024.

²⁵ National Hospice and Palliative Care Organization, “*Staffing Guidelines for Hospice Home Care Teams*,” Page 33, Published 2016, Last accessed on November 04, 2024.

²⁶ National Hospice and Palliative Care Organization, “*Measures of Excellence National Report 2021-2022*,” Page 62, Published 2023.

²⁷ Hospice News, “*Hospice Case Manager Workloads Correlate with Longer Stays, Profitability*,” September 23, 2022, <https://hospicenews.com/2022/09/23/hospice-case-manager-workloads-correlate-with-longer-stays-profitability/>.

being of nurses to ensure they do not become overwhelmed by their caseloads and experience “burnout.”

This section establishes definitions for ‘licensed nurse’ and ‘assigned’ to ensure consistent interpretation and enforceability, modeled after GACH regulations under Title 22 CCR section 70217(a). It is necessary for the Department to define these terms in the regulatory text because they are not included in section 74800, as they only pertain to this section, and leaving them open to interpretation would undermine the intent of HSC section 1753.1(b). Leaving these terms undefined would also make it extremely difficult for Department surveyors to enforce the requirements of this section.

Adopt subdivision (c). Subdivision (c) requires policies for on-call staffing and emergency communication to ensure timely support for patients and staff. This requirement is necessary to protect the health and safety of patients.

Adopt subdivision (c)(1) to ensure hospice agencies establish a policy and procedure for outlining the most appropriate method for determining staffing for on-call nursing services. This is necessary to fully effectuate the requirements of subdivisions (a) and (b), while still giving autonomy to hospice agencies by allowing them to determine the most appropriate method of execution based on the staff and resources available to each individual agency.

Adopt subdivision (c)(2) to ensure hospice agencies have proper protocols in place for how nursing personnel can and should contact management personnel for after-hour assistance, if needed. This is necessary in the event of an emergency or if a situation arises that the nursing personnel on call needs additional guidance and/or clarification from a physician that cannot wait. Hospice patients suffering from terminal illnesses often experience rapid unexpected changes to their health that will require immediate attention. Personnel should therefore be able to receive management assistance in times of an emergency to protect the patient’s dignity through the dying process.

Subdivisions (d)–(e) clarify that ratios apply to nurses providing direct patient care and limit LVN assignments to tasks within their scope of practice to protect patient safety.

Adopt subdivision (d) to clarify to the regulated community what type of nurses can and should be included in the nurse-to-patient ratio standard under subdivision (b). The statutory mandate for the Department to develop a nurse-to-patient ratio under HSC section 1753.1(b) is silent on what type of nurses must be included, however after several discussions with subject matter experts and taking into consideration all feedback received from stakeholders, the Department determined it would be most appropriate to have the ratio apply to nurses who are responsible for direct patient care. In a hospice environment where patients typically reside in their homes, one RN is assigned to a patient’s interdisciplinary team to manage and coordinate all care and services, but Licensed Vocational Nurses (LVNs) can be tasked with handling day-to-day nursing care on behalf of RNs where appropriate, so long as it is within their scope of practice. This proposed regulation is modeled after GACH standards of practice as

seen in Title 22 CCR section 70217(a) and is necessary to clarify the type of “nurses” that are subject to the patient ratio requirement. This proposed regulation is also necessary to make clear that the ratio only applies to licensed nurses employed by or contracted with the hospice, even if for example, a hospice patient resides in a skilled nursing facility or is receiving services in a hospital or other inpatient setting.

Adopt subdivision (e) to set a standard that LVNs can only be assigned to care for patients that is appropriate for their scope of practice. Department surveyors have observed that nurses without the experience and education of an RN, such as LVNs, are not able to adequately perform certain tasks which could put the patient in jeopardy. For example, assessing patients at potential moments of transition such as admission to, recertification of, or discharge from hospice. The adoption of this regulation is necessary to protect the health and safety of patients by ensuring they receive the best quality care from nursing personnel that are properly trained and qualified to perform the required task.

Subdivisions (f)–(i) require hospices to implement and annually review a patient acuity system to ensure equitable caseloads and prevent nurse burnout, with input from staff and timely adjustments.

Adopt subdivisions (f) and (f)(1) through (f)(6) to ensure hospice agencies develop and implement guidelines for determining how to appropriately manage personnel caseloads based on the severity of their assigned patients’ conditions. For example, personnel assigned to patients with conditions that require more frequent visits, and a lot of time and attention, will not be able to carry as high of a caseload as personnel assigned to patients who only require basic routine care. The Department asked stakeholders to provide guidance on any current industry standards of practice and was informed there were none in place because it is not a “one size fits all” approach. While the Department is sensitive to that concern, guidelines are necessary to ensure personnel caseloads are assigned proportionately and fairly to protect the wellbeing of hospice personnel, and the health and safety of their patients. The proposed patient acuity system follows a similar model as seen in Title 22 GACH regulations under section 70217 subdivisions (b) through (h). In conjunction with the newly implemented nurse-to-patient ratio requirement of this section, the required patient acuity system is an added layer to help prevent “burn out” for hospice nurses in California.

Adopt subdivision (g) to clarify to the regulated community that personnel other than RNs and LVNs may provide care to a patient when appropriate. The Department was statutorily required to set a nurse-to-patient ratio under HSC section 1753.1(b). However, hospice care can be unpredictable at times because the dying process is not the same for every person. The proposed regulation provides guidance to the regulated community regarding personnel that may provide care above the minimum ratio. This proposed regulation is necessary because it allows hospice agencies to allocate resources and personnel to properly attend to high-need patients without the risk of becoming noncompliant with the nurse-to-patient ratio requirement.

Adopt subdivisions (g)(1) through (g)(5). These factors were modeled after GACH regulations under Title 22 CCR section 70217(b) and adjusted to apply to the hospice care environment. It is necessary for the hospice to consider these factors about the patient's condition to ensure additional personnel is warranted, and that the right type of personnel gets assigned. For example, a patient with a severe illness that requires specialized equipment would likely be justified for having additional personnel added to their care team; however, a volunteer may not be the right fit, and a medical professional should be assigned. This proposed regulation is necessary to protect the health and safety of hospice patients by ensuring they receive appropriate and necessary care.

Adopt subdivisions (g)(6) through (g)(10) outlining a few additional factors that should be considered when assessing the appropriate staffing level above the prescribed nurse-to-patient ratio. These additional factors were submitted to the Department via written feedback from a stakeholder and the Department agreed that these factors could affect the additional personnel that may be needed to provide care to a patient.

Adopt subdivision (h) requiring hospice agencies to develop policies and procedures to effectuate the patient acuity system described in subdivision (g). As previously mentioned, stakeholders have stated there it is not a "one size fits all" approach for determining patient acuity levels for hospice patients, therefore the Department's goal is to provide the flexibility for each agency to determine the best method and criteria that will be appropriate for their patient demographic. This proposed regulation is necessary to ensure hospice agencies have a mechanism in place for how patient acuity should be determined which must be used to identify the level of care and attention each patient requires to appropriately assign nurse caseloads.

Adopt subdivision (i) requiring hospice agencies to review their patient acuity system at least annually. This requirement follows current standards of practice under GACH regulations as seen in Title 22 CCR section 70217(a) and is necessary to ensure hospice agencies are regularly checking to confirm that the policies, procedures, and protocols in place are working as expected. The purpose of the patient acuity system is to create manageable caseloads for nursing personnel to ensure they do not experience "burnout" and to protect the health and safety of patients by ensuring their assigned nurses are not too overburdened to provide quality care.

Adopt subdivision (i)(1) to align with Title 22 CRR section 70217(f), which is necessary to ensure that input is received and considered from individuals who have first-hand experience with how the current acuity system is implemented. A hospice RN's day-to-day duties will be directly affected by the staffing requirements of this section and the implementation of a patient acuity system; therefore, it is imperative for these individuals to hold committee member positions to provide honest feedback of whether or not the system is working.

Adopt subdivision (i)(2) to align with Title 22 CCR section 70217(g) which is necessary to ensure that any concerns regarding the current system's effectiveness are addressed in a timely manner. Thirty days is a reasonable amount of time to make any needed adjustments to protect the well-being of hospice nurses and the health and safety of patients.

Adopt subdivisions (i)(3) and (i)(3)(A) through (i)(3)(D) requiring hospice agencies to capture and record a general synopsis of each patient acuity review meeting. This proposed regulation is necessary for Department surveyors to confirm important information such as what adjustments were suggested and implemented, if the adjustments were made within the required 30-day timeframe, and that the hospice Administrator attests the accuracy of the record by way of signature.

Adopt subdivision (i)(4) to align with Title 22 CCR section 70217(h), which is necessary to ensure any other interested parties affected by the patient acuity system such as volunteers, home health aides, or other members of the hospice interdisciplinary team have the opportunity to give feedback and suggestions. The best and only way for a hospice to ensure that the patient acuity system it developed is effective would be through testimony from the individuals that have direct experience implementing and effectuating these requirements.

Adopt subdivision (j). Subdivision (j) permits occasional assistance between nurses for non-routine tasks, consistent with Title 22 CCR section 70217(a), without undermining ratio requirements. This is necessary to clarify to the regulated community that even with the nurse-to-patient ratio in place, nurses are still allowed to help and "assist" one another on occasion, so long as it meets the provided definition. The definition is in alignment with current standards of practice for GACH regulations under Title 22 CCR section 70217(a), and appropriate for the use of this section because it very specifically clarifies that a nurse may only "assist" another nurse for limited non-regular instances. If assistance from another nurse begins to happen repeatedly or the tasks become more generic, then that is a signal the assigned nurse is likely overburdened, and their caseload should be re-evaluated. This proposed regulation is necessary to maintain the intent of HSC section 1753.1(b) while still providing hospice nurse personnel some flexibility should it be needed for irregular and unforeseen circumstances.

Adopt section 74852 "Director of Patient Care Services."

Section 74852 establishes qualifications and responsibilities for the Director of Patient Care Services (DPCS) to ensure effective oversight of hospice nursing programs and compliance with Health and Safety Code section 1753.1(d).

Adopt subdivision (a). Subdivision (a) requires the governing body to appoint the DPCS to ensure accountability and proper oversight of hospice operations. This is necessary to set a standard that key hospice management personnel such as the Director of Patient Care Services (DPCS) are selected by the governing body. This is necessary to ensure that the individuals who have responsibility for the operation of the

hospice program are aware and confident in the appointment of the program's managers who will carry out the day-to-day duties on behalf of the governing body.

Adopt subdivision (b). Subdivision (b) establishes minimum education and experience requirements for DPCS and Designees, modeled after CHAPCA and HHA standards, with modifications to address California's nursing shortage while ensuring patient safety. This is necessary to establish the standard for the minimum experience and qualifications an individual must have to be eligible to serve as the DPCS or DPCS Designee of a hospice. This proposed regulation is necessary to ensure the appointed person is qualified to perform the required functions of the position. The listed options were influenced from the DPCS education and experience requirements found in the CHAPCA Standards and from HHA regulations. The requirements for an HHA DPCS were used for consideration because HHAs are the most similarly related Title 22 facility type. For more information regarding the justification for these two options, please see (b)(1) and (b)(2) below.

Adopt subdivision (b)(1). Subdivision (b)(1) permits RNs with a baccalaureate degree and two years of full-time supervisory experience in hospice or home health within the last five years to qualify, ensuring relevant experience while expanding the candidate pool. This is necessary to establish one path to qualify for a hospice DPCS or DPCS Designee position. Section 5.3(D)(1) of the CHAPCA Standards allows a RN to qualify for the position "with a baccalaureate or higher degree in nursing or another health-related field with three years of experience within the last five years in a hospice or home health agency, primary care clinic or health facility, at least one year of which was in a supervisory or administrative capacity."²⁸ HHA regulations for DPCS education and experience requirements under Title 22 CCR section 74703(b) are nearly identical to CHAPCA's, however HHA regulations do not accept hospice work experience to qualify as a HHA DPCS. The Department made a few edits that are more appropriate for hospices as follows:

- Instead of allowing "three years of experience within the last five years... at least one which was in a supervisory capacity," this proposed regulation requires only two years of experience within the last five years, but both years must have been in a supervisory role. This slightly lower experience requirement was chosen to balance the need for qualified hospice management personnel, pursuant to HSC section 1753.1(d), while also taking into account the state of the nursing workforce in California. This requirement was also discussed with and supported by stakeholders and subject matter experts.
- The Department chose to require full-time supervisory or managerial experience to ensure the candidate has enough experience to properly perform the necessary job duties. The hospice DPCS and DPCS Designees are very

²⁸ California Hospice and Palliative Care Association, "Standards of Quality Hospice Care, 2005," Page 14, Last accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

important roles within the hospice that are responsible for overseeing the nursing program. Quality nursing care is critical for hospice patients who are terminally ill, therefore this proposed regulation was intended to protect the health and safety of patients.

- Instead of accepting experience from a primary care clinic or health facility like CHAPCA and HHA regulations, this proposed regulation only allows experience from a hospice or home health agency. The Department is legislatively mandated under HSC section 1753.1(d) to set “hospice specific” training and experience standards for management personnel, therefore allowing an individual to qualify for a hospice DPCS position with experience from a primary care clinic would undermine the intent of HSC section 1753.1(d). Stakeholders have expressed that the experience and demands of working with patients receiving care in their homes is vastly different from working with patients in an outpatient setting or located together inside a facility. For that reason, the Department is proposing to only allow hospice specific experience, or HHA experience because HHA is very similar to hospices where care is provided to patients in their home environments.

This proposed regulation is necessary to meet the intent of HSC section 1753.1(d) by clarifying how much and what types of experience are necessary to qualify for a DPCS position to ensure the appointed individual has enough recent and relevant experience to perform the required functions, while still allowing reasonable alternatives to qualify to increase the candidacy pool and not overly burden hospice hiring efforts.

Adopt subdivision (b)(2). Subdivision (b)(2) provides an alternative qualification for RNs without a degree, requiring four years of hospice or home health experience within the last five years, including supervisory duties, to ensure competency. This is necessary to establish a second path to qualify for a hospice DPCS or DPCS Designee position. Section 5.3(D)(2) of the CHAPCA Standards allows a RN to qualify for the position “with four years of experience within the last five years in a hospice, home health agency, primary care clinic or health facility, at least one year of which was in a supervisory or administrative capacity.”²⁹ HHA regulations are nearly identical to CHAPCA again, however HHA regulations do not accept hospice work experience to qualify as a HHA DPCS. The Department mirrored this option, with the modification that only hospice or HHA experience can be accepted for the same reason identified above in subdivision (b)(1). This proposed regulation provides an alternative option for individuals who do not have a baccalaureate degree in nursing or another health-related field to qualify for a hospice DPCS position. Increasing the work experience minimum from two to four years as the second option to qualify was intended to offset the lack of structured schooling with additional on-the-job experience to ensure the candidate will

²⁹ California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Page 14, Last accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

be able to successfully apply their long-standing experience to the requirements of a hospice DPCS position.

Subdivisions (c)–(h) require a qualified designee when the DPCS is unavailable, prohibit appointment of individuals with recent disciplinary actions, limit DPCS to one agency (with rural exceptions), mandate filling vacancies within 60 days, and allow extensions with documented recruitment efforts and safety assurances.

Adopt subdivision (c) to ensure that one designated individual will be available and responsible for carrying out the responsibilities of the position if the primary DPCS is unavailable for any reason. This appointment is necessary to ensure that whoever is filling in to manage the hospice is appropriately qualified and easily identifiable to hospice staff as the next point of contact for any needed assistance.

Adopt subdivision (d) to re-clarify to the regulated community that a person cannot be appointed as DPCS of a hospice if they have had disciplinary action taken against them as outlined in detail under section 74832 (Denial of Application). For more information regarding disciplinary actions that disqualify an individual from serving as hospice management personnel within the last seven years please refer to section 74832(b). This proposed regulation is necessary to protect patients from management who have acted in an unprofessional manner.

Adopt subdivision (e) to set a standard that a DPCS can only manage and be responsible for one hospice agency. A concern from the Audit Report was that management staff were overseeing too many agencies to be able to provide quality care to patients, therefore the Department was legislatively mandated to limit the number of hospices that management staff can be involved with under HSC section 1753.1(c). There are currently no limits on the number of agencies that hospice management personnel can work for in the CMS CoPs, the CHAPCA standards, or similarly related Title 22 facility types. Mississippi has regulations in place that prohibit a Director of Nursing from having simultaneous employment with another hospice agency.³⁰ CHAPCA's recommendation to the Department was that the DPCS should be limited to managing one hospice due to the nature of the role. Depending on the size of the hospice and the experience of the appointed individual, a DPCS could be tasked with additional roles and responsibilities and be required to oversee additional hospice personnel, all in addition to managing the hospice nursing program, which would demand a lot more time and attention. Department subject matter experts were supportive of this limit as well based on the requirements of the position.

After careful consideration of recommendations from stakeholders and subject matter experts, the Department determined that a hospice DPCS should be limited to overseeing only one agency. This proposed regulation is necessary to fulfill the Department's statutory obligation under HSC section 1753.1(c) which will help to ensure

³⁰ 1.35.4 Miss. Code Ann. §41-85-7.

hospice personnel receive the support they need from management to provide the highest quality care to patients.

Adopt subdivision (f) to allow an exemption for a hospice DPCS serving a rural area to manage one additional hospice agency in that same rural area, if needed. Hospice agencies located in rural areas are likely to have lower patient counts due to the smaller population of the area; therefore, it is reasonable for a DPCS to manage two small hospice agencies because they are likely comparable in size to one hospice agency located in an urban area. This is necessary to meet the intent of HSC section 1753.1(c) without being overburdensome to rural hospice agencies that may struggle to employ and retain qualified management personnel due to their remote location.

Adopt subdivision (g) to require a vacant DPCS position to be filled within 60 days from when the vacancy occurs. This mirrors current practice under section 5.3(C) of the CHAPCA Standards. This is intended to ensure that the hospice's quality and adequacy of services provided to patients does not diminish without a manager to oversee the program for a prolonged period of time. The Department determined that 60 days is a reasonable amount of time for hospices to hire a replacement.³¹ Allowing the DPCS position vacant for too long could jeopardize the health and safety of patients therefore this proposed regulation is necessary to protect patients. This proposed regulation is also necessary to remain consistent with section 74828 (Report of Changes) which requires that once a new DPCS is appointed, a hospice must notify the Department by submitting an application to the Department within 10 business days as required under HSC section 1749(b)(3).

Adopt subdivision (h) giving hospices the opportunity to apply for an extension if they are unable to fill a vacant DPCS position within the required 60 days as required under subdivision (g). This proposed regulation is necessary to clarify the specific steps and documentation that is required to qualify for the extension. The Department must be able to ensure that the agency requesting the extension did its due diligence and made reasonable efforts to fill the vacancy prior to approving such a request. The Department must also be assured that the extended vacancy will not pose a risk to the health and safety of patients.

Adopt subdivision (h)(1) and (h)(1)(A) through (h)(1)(C) requiring documented proof demonstrating the hospice's efforts to hire a DPCS replacement. This is modeled after a CMS nursing waiver requirement under Title 42 CFR 418.66(a)(3) which requires similar substantiation to be submitted if a hospice is unable to directly provide nursing services. It is reasonable and appropriate to require the hospice to submit documentation to ensure they are doing their due diligence and actively trying to recruit before an extension is approved, without being overburdensome.

³¹ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 13, Last accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivision (h)(2) requiring hospices to submit an attestation that an approved extension for the DPCS position will not pose a risk to the health and safety of their patients. The role of a DPCS is to oversee the hospice nursing program including managing nursing personnel, therefore if this position is vacant for an extended period of time without oversight from a qualified individual it could lead to unintended consequences such as mismanagement or improper care for patients. The hospice agency must demonstrate it has a mechanism in place to prevent potential harm despite the vacancy. This proposed regulation is necessary to protect the health and safety of patients.

Adopt section 74856 “Medical Director.”

Section 74856 establishes qualifications and responsibilities for the Medical Director to ensure effective oversight of hospice care and compliance with Health and Safety Code section 1753.1(d).

Adopt subdivision (a). Subdivision (a) requires the governing body to appoint the Medical Director to ensure accountability and proper oversight of hospice operations. This requirement is necessary to set a standard that key hospice management personnel such as the Medical Director must be selected by the governing body. This is necessary to ensure that the individuals who have responsibility for the operation of the hospice program are aware and confident in the appointment of the program’s managers who will carry out the day-to-day duties on behalf of the governing body.

Adopt subdivision (b). Subdivision (b) establishes minimum education and experience requirements for Medical Directors and Designees, modeled after CHAPCA and federal standards, with modifications to allow hospice, HHA, or palliative care experience to expand the candidate pool while ensuring patient safety. This requirement is necessary to establish a standard for the minimum experience and qualifications an individual must have to be eligible to be the Medical Director or Medical Director Designee of a hospice which is necessary to ensure the appointed person is qualified to perform the required functions of the position. For more information regarding the justification for these requirements, please see (b)(1) and (b)(2) below.

Adopt subdivision (b)(1). Subdivision (b)(1) requires the Medical Director to hold a valid California medical license, consistent with CHAPCA standards and Title 42 CFR section 418.102. This requirement is necessary to ensure the individual is licensed to practice Medicine in the State of California which is necessary for the safety and protection of patients. This proposed regulation is consistent with the definition of a Medical Director in the CHAPCA Standards and with the Medical Director CoPs in Title 42 of the Code of Federal Regulations (CFR) section 418.102.³²

³² California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Page 3, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivision (b)(2). Subdivision (b)(2) requires two years of full-time supervisory or managerial experience within the last five years in hospice, HHA, or palliative care to ensure competency and compliance with HSC section 1753.1(d). This requirement is necessary to establish the minimum work experience requirements for a hospice Medical Director or Medical Director Designee which is necessary to ensure the appointed individual is qualified to perform the duties of the position. Current standards of practice under the CHAPCA Standards require Medical Directors to have hospice or palliative care specific experience, however it does not specify how many years of experience should be met. For consistency among all three hospice management personnel positions the Department adopted the same standard that was set for DPCS. For more information regarding the justification for two years of full-time supervisory or managerial experience within the last five years, please refer to section 74852 (Director of Patient Care Services) subdivision (b)(1).

Also, similar to section 74852 for DPCS, the Department is required under HSC section 1753.1(d) to set “hospice specific training and experience” standards for hospice management personnel. However, to allow for some flexibility because of feedback from the regulated community that the experience requirements were too limiting, HHA and palliative care work experience will be accepted to qualify for the Medical Director and Medical Director Designee positions. HHAs are the most similarly related facility type to hospice agencies where care is provided in the patient’s home, therefore it was reasonable and appropriate to include this type of work experience. Additionally, the current standard of practice under Section 5.2 of the CHAPCA Standards allows experience in palliative care as an option which will potentially expand the candidacy pool for hospices.³³ This proposed regulation is necessary to meet the intent of HSC section 1753.1(d) by clarifying how much and what types of experience are necessary to qualify for this position while remaining consistent with other hospice management personnel positions.

Subdivisions (c)–(j) require a qualified designee when the Medical Director is unavailable, allow employment flexibility, prohibit appointment of individuals with recent disciplinary actions, limit Medical Directors to one agency (with rural exceptions), mandate filling vacancies within 60 days, and allow extensions with documented recruitment efforts and safety assurances.

Adopt subdivision (c) to require a specific individual to be designated and responsible for carrying out the responsibilities of the position if the primary Medical Director is unavailable for any reason. It is reasonable to include this requirement to align with the other two hospice management personnel positions that must have an assigned Designee. The appointment of a Medical Director Designee is necessary to ensure that whoever is filling in is appropriately qualified and easily identifiable to hospice staff as the next point of contact for any needed assistance. This requirement is also in

³³ California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Page 13, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

alignment with federal regulations which use the term a “physician designee” as seen under Title 42 CFR section 418.25.

Adopt subdivision (d) to clarify for the regulated community that a Medical Director may be employed by or under contract with the hospice agency which is consistent with federal CoPs under Title 42 CFR section 418.102. Additionally, the proposed regulation clarifies that a hospice Medical Director “may work full time or part time” according to an interpretive guideline in the State Operations Manual (SOM).³⁴

Adopt subdivision (e) to re-clarify to the regulated community that an individual cannot be appointed as Medical Director of a hospice if they have had disciplinary action taken against them as outlined in detail under section 74832 (Denial of Application) subdivision (b). This is necessary to protect patients from management who have previously acted in an unprofessional manner.

Adopt subdivision (f) to set a standard that a Medical Director can only manage and be responsible for one hospice agency. A concern from the Audit Report was that management staff were overseeing too many agencies to be able to provide quality care to patients, therefore the Department was legislatively mandated to limit the number of agencies that hospice management personnel can be involved with under HSC section 1753.1(c). There are currently no limits on the number of hospices management personnel can work for in CMS CoPs, the CHAPCA standards, in similar Title 22 facility types, nor in the regulations of any other state. Upon recommendation from CHAPCA however, a hospice Medical Director should be limited to managing only one hospice due to the nature of the role. Depending on the size of the hospice and the experience of the appointed individual, a Medical Director could be tasked with taking on additional roles and responsibilities within the hospice which would demand a lot more time and attention. After careful consideration of recommendations from stakeholders and subject matter experts, the Department established that a Medical Director must be limited to overseeing one hospice agency.

Adopt subdivision (g) to allow an exemption for Medical Directors serving a rural area to manage a maximum of three hospice agencies. This is necessary to meet the intent of HSC section 1753.1(c), which requires CDPH to establish a limit for the number of hospice agencies that hospice agency management personnel can be involved with concurrently, without being overburdensome to rural agencies that may have difficulty finding and retaining qualified physicians to serve remote areas.

Adopt subdivisions (h), (h)(1), and (h)(2) to be consistent with hospice federal CoPs under Title 42 CFR section 418.102(a)(1). This proposed regulation is necessary to clarify the specific requirements and guidelines for a hospice agency to contract with a

³⁴ State Operations Manual, “Appendix M – Guide to Surveyors: Hospice,” Page 144, Last accessed on September 19, 2024, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf.

physician under subdivision (d) above.

Adopt subdivision (i) for the same reasons outlined under section 74852 (Director of Patient Care Services) subdivision (h). Sixty days is a reasonable amount of time for hospices to hire a replacement. This proposed regulation was applied to the Medical Director position for consistency among all hospice management personnel. This proposed regulation is also necessary to remain consistent with section 74828 (Report of Changes), which requires that once a new Medical Director is appointed a hospice must notify the Department by submitting an application to the Department within 10 business days to remain consistent with the requirement under HSC section 1749(b)(3).

Adopt subdivision (j) giving hospices the opportunity to apply for an extension if they are unable to fill a vacant Medical Director position within the required 60 days as required under subdivision (i). This proposed regulation is necessary to clarify the specific steps and documentation that is required to qualify for the extension. The Department must be able to ensure that the agency requesting the extension did its due diligence and made reasonable efforts to fill the vacancy prior to approving such a request for consistency. The Department must also have assurances that the extended vacancy will not pose a risk to the health and safety of patients.

Adopt subdivisions (j)(1) and (j)(1)(A) through (j)(1)(C) for the same reasons identified in section 74852 (Director of Patient Care Services) subdivisions (i)(1) and (i)(1)(A) through (C). The Department implemented the same requirements for the Medical Director position to maintain consistency among all hospice management personnel positions.

Adopt subdivision (j)(2) requiring hospices to submit an attestation that an approved extension for the Medical Director position will not pose a risk to the health and safety of their patients. If this position is vacant for an extended period of time without oversight from a qualified individual it could lead to unintended consequences such as mismanagement or improper care for patients. The hospice agency must demonstrate they have a mechanism in place to prevent potential harm. This proposed regulation is therefore necessary to protect the health and safety of patients.

ADOPT ARTICLE 4 “PLAN OF CARE”

Adopt section 74860 “Admission.”

Section 74860 establishes uniform admission criteria and procedures for hospice providers. This section is necessary to establish who may be admitted and the actions required at admission, ensuring clear expectations for providers and surveyors. Codifying these criteria is necessary to reduce errors, ensure complete and accurate records, and support uniform oversight during licensure surveys.

This adoption is necessary to fully effectuate the hospice emergency regulations pursuant to HSC section 1753.1 and set clear guidelines outlining who can be admitted for service, and what must occur when they are admitted. There are currently no

regulations or guidelines for these assessments under the California Hospice Licensure Act of 1990. HSC section 1749(e) directs hospice agencies to follow the CHAPCA Standards until the Department promulgates regulations.³⁵ The CHAPCA Standards however are silent on this topic. The Department is aligning this section with federal CoPs under Title 42 CFR section 418.25 which implements a few key admission requirements. Having regulations in place will create consistency and clarity for the regulated community and will also allow Department surveyors to provide oversight for agencies in a consistent manner.

Adopt subdivision (a). Subdivision (a) requires that each hospice must maintain written admission policies and procedures that: (1) define eligibility for admission; (2) describe step by step admission actions, including consent and documentation; and (3) identify any qualifications or conditions the hospice must meet at admission. These policies are necessary to standardize admission, ensure complete and accurate records, and support consistent Department review.

Adopt subdivision (a)(1). Subdivision (a)(1) requires that the hospice must adopt documented admission protocols that guide clinical staff through the admission process for a new patient. The protocols must address eligibility confirmation, required consents, documentation, and communication to the interdisciplinary team. Standardized protocols are necessary to ensure timely initiation of services, consistent patient and family communication, and reliable handoffs to the care team.

Hospice admission nurses should have documented protocols in place to follow if needed to help address any issues that may not be covered in this section. Admission to hospice is an emotional experience for the individual and their family because it represents the last stage of life, therefore it is necessary to ensure hospice agencies take all possible measures to ensure a smooth and comfortable transition for all parties.

Adopt subdivision (a)(2). Subdivision (a)(2) requires that a patient can only be admitted for hospice services under physician orders. This requirement is necessary to ensure clinical authorization, protect patient safety, and prevent admission of individuals who do not meet hospice eligibility. This proposed regulation aligns with Title 42 CFR 418.25(a), which is discussed in more detail under subdivision (c) and is necessary to ensure patients without a terminal illness are not unnecessarily admitted to hospice. Admitting a person to hospice when they do not need such services could be detrimental to that individual's health because they would be forgoing necessary curative treatments.

Adopt subdivision (a)(3). Subdivision (a)(3) requires hospice agencies to accept only those patients whose needs it can meet, consistent with section 74868 (Plan of Care). If a hospice agency does not offer the types of services that a patient's condition

³⁵ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

requires or does not have the resources to support the level of care and attention the patient requires, accepting that individual would deprive the patient of the opportunity to receive all necessary care and services elsewhere. This requirement is necessary to ensure adequate resources, appropriate services, and safe initiation of care to protect the health and safety of patients.

Adopt subdivision (b). Subdivision (b) identifies two pathways for admission: (1) hospice care for individuals with a diagnosed terminal illness; and (2) preliminary hospice services. This requirement is necessary to establish these pathways to guarantee consistent admission decisions.

Adopt subdivision (b)(1). Subdivision (b)(1) establishes the first path to be admitted to hospice is for a need for hospice care along with a diagnosed terminal illness. Admission may occur when the patient elects to receive hospice care and has a diagnosed terminal illness. Section 74800(a)(55) adopts the definition under current statute from HSC section 1746(p) which defines “terminal disease” or “terminal illness” as “a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.” For purposes of this chapter, “terminal illness” means a life expectancy of 12 months or less. Clarifying this definition is necessary to ensure consistent eligibility determinations and patient protection. It is necessary to have a physician confirm the presence and diagnosis of a terminal illness to admit a patient because hospices do not provide any curative treatments, which means that if a patient is admitted to hospice without a terminal illness, then they would be forgoing other treatment options.

This proposed regulation is also necessary to clarify to the regulated community that the Department considers “terminal illness” to be a prognosis of life of 12 months or less as defined in HSC section 1746(p), as opposed to a prognosis of 6 months or less as seen in federal regulations under Title 42 CFR section 418.3. This is extremely important to clarify for the regulated community because the state and federal definitions being different could cause confusion. The Department is clarifying the expectation that hospices and their personnel must comply with the state definition found in HSC.

Adopt subdivision (b)(2). Subdivision (b)(2) establishes the other options listed in HSC section 1749(g). Admission may also occur for preliminary hospice services, including palliative care consultations, counseling and care planning, and grief and bereavement support. This option is necessary to provide early assistance and support a timely transition to hospice when needed. This is necessary to ensure that individuals who are anticipating the need for hospice services are still able to get critical care and support that will help pave the way for a more smooth and comfortable transition onto hospice when necessary. Also, adopting this regulation will align with the statute.

Adopt subdivision (c). Subdivision (c) establishes that the hospice Medical Director shall certify the patient’s terminal illness in collaboration with the patient’s attending physician, if any. The certification shall apply the definition of “terminal illness” used in this chapter. This requirement is necessary to ensure consistent clinical determination

and reliable documentation. This requirement is necessary to remain consistent with subdivision (b)(1) and further clarify that the Hospice Medical Director is responsible for certifying a patient's terminal illness prognosis, in collaboration with the patient's attending physician, as defined in Article 1 of this chapter. This requirement follows current standards of practice for federal CoPs under Title 42 CFR section 418.25(a), which states, "The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician, if any," with one major difference being that this proposed regulation requires physicians to follow the definition of "terminal illness" as identified under section 74800(a)(55) instead of CFR's definition.

Adopt subdivision (c)(1). Subdivision (c)(1) establishes that a covering hospice physician may act on behalf of an attending physician when the attending is unavailable or when no attending has been designated. This provision is necessary to ensure physician availability and continuity of care. This requirement is necessary to clarify that a covering hospice physician may act on behalf of a patient's attending physician under certain circumstances, such as if the patient's attending physician is unavailable, or if the patient does not have an attending physician. This requirement is consistent the definition of "attending physician" under the CHAPCA Standards and with the physician's services requirement under Title 42 CFR 418.64(a)(3).³⁶ This requirement is also necessary to protect the health and safety of patients by ensuring a qualified physician will always be available to provide expertise and guidance over the medical component of a patient's care.

Adopt subdivision (c)(2). Subdivision (c)(2) establishes that certifying physicians shall sign documentation attesting to collaboration and examination of the patient and confirming the terminal illness. Physician signatures are necessary to ensure traceable records and facilitate survey verification. This requirement is necessary to establish that the certifying physician has confirmed the patient's terminal illness prognosis as defined in section 74800(a)(55). This proposed regulation is necessary for Department surveyors to be able to verify that the patient received certification from both required parties, and surveyors will be able to easily identify which physicians performed the certification.

Adopt subdivisions (c)(3) and (c)(3)(A) through (c)(3)(D) to mirror the current standard of practice in the federal CoPs under Title 42 CFR 418.22(b), requiring the certifying Medical Director to record specific pieces of information in their documentation. The listed information that must be included is necessary to protect the health and safety of patients by ensuring that the certifying physicians are able to substantiate their findings and decision to validate a patient as terminally ill. Like subdivision (b)(1), the Department requires certifying personnel to follow a life expectancy of 12 months or less, which is different than the requirement found under

³⁶ California Hospice and Palliative Care Association, "Standards of Quality Hospice Care, 2005," Page 1, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

federal CoPs.

Adopt subdivision (c)(4) to ensure that all the above required information and documentation related to a patient's initial certification of terminal illness is preserved in the patient's medical record. This is necessary to ensure all members of a patient's hospice interdisciplinary team have full transparent access to the patient's diagnosis, and to ensure Department surveyors will be able to easily enforce the requirements of this section.

Adopt subdivisions (d) and (d)(1) through (d)(5). Subdivision (d) establishes that before confirming a prognosis, certifying physicians shall consider the topics listed in subdivision (d)(1)–(5). This requirement is necessary to ensure comprehensive review of the patient's condition and accurate clinical determinations. This proposed regulation is consistent with federal CoPs under Title 42 CFR 418.25(b) and is necessary to ensure the certifying physician(s) have a clear picture of a patient's full medical history and condition. This will allow them to accurately determine whether the patient qualifies for a certification of terminal illness.

Adopt subdivision (e). Subdivision (e) establishes that at admission, the hospice shall complete the assessments and documentation required by this section to initiate care appropriate to the individual. This requirement is necessary to ensure orderly and timely initiation of services and to set a standard for what must occur at the time a patient is admitted for service. This is necessary to ensure that all necessary assessments and documentation are completed to begin providing care appropriate for the individual.

Adopt subdivision (e)(1). Subdivision (e)(1) establishes that a hospice RN shall complete the initial assessment within 48 hours of admission. Timely assessment is necessary to identify immediate needs and prevent delays or gaps in care. This is necessary to ensure that a patient receives an initial assessment within 48 hours of admission to hospice. The admission process, including specific steps and requirements to complete an initial assessment, is outlined in detail under section 74864(a) (Assessments). This requirement ensures a hospice RN contacts a newly referred patient right away to determine what type of immediate care and support the patient and their family requires, which is also consistent with federal CoPs under Title 42 CFR 418.54(a). Receiving a referral to hospice is an emotional experience for patients and their families because it signifies impending death. Timely completion of a patient's initial assessment is therefore necessary to ensure there are no unnecessary delays or gaps in care which could be detrimental to the health of a terminally ill person and is also necessary to provide a seamless and comfortable transition to hospice for the patient and their family.

Adopt subdivision (e)(2). Subdivision (e)(2) establishes that at admission, the hospice shall provide information created by the hospice to the patient or patient's representative regarding advance directives and the patient's rights. This requirement is necessary to support informed decision making and respect patient preferences. The hospice is responsible for creating the materials because they will be written to reflect

each individual hospice's policies and procedures. This requirement is necessary to ensure hospice agencies provide clear information regarding advance directives to a patient or the patient's representative at the time of admission. An advance directive, like a living will, is a legal document that the patient or patient's representative can complete to ensure their medical wishes and requests are honored by their care providers. Advance directives are generally only used in instances when the patient is unable to communicate their desires on their own or no longer has the cognitive ability to make their own medical decisions. Hospice patients may benefit from completing advance directives because they are in the last stage of life and are likely to find themselves unable to make decisions due to the natural progression of their conditions. Patients and their families who are being admitted to hospice are likely feeling distressed, fearful, and emotionally overwhelmed; therefore, it should be the hospice agency's duty to make patients and their representatives aware of their right to complete and submit advance directives. This proposed regulation is necessary for hospice agencies to help support patients and their families during their most vulnerable times and protect a patient's dignity throughout the dying process which is at the core of hospice services.

Adopt subdivision (e)(2)(A). Subdivision (e)(2) establishes that the hospice shall provide written information describing its advance directive policies, the benefits of advance directives for hospice patients, the patient's right to refuse treatment, and how and when directives are implemented. Providing this information is necessary to promote transparency and support advance care planning. This requirement is necessary to align with federal CoPs under Title 42 CFR 418.52(a)(2) requiring hospice agencies to provide information about the agency's advance directive policies including information about the benefits for hospice patients to complete advance directives. This is necessary because there are many benefits for a hospice patient to complete and submit advance directives. For example, "by planning ahead you can get the medical care you want, avoid unnecessary suffering and relieve caregivers of decision-making burdens during moments of crisis or grief. You also help reduce confusion or disagreement about the choices you would want people to make on your behalf."³⁷

Many people may not know about or be familiar with advance directives, therefore it is important for hospice agencies to make new patients aware of their existence and of the benefits of completing one as soon as possible upon admission. This will help to protect a patient's dignity throughout the dying process by ensuring patients and their representatives have all the information and opportunities available to them to make quality medical decisions.

Adopt subdivision (e)(2)(A)(i). Subdivision (e)(2)(A)(i) establishes that written materials shall inform the patient and family of the patient's right to refuse treatment.

³⁷ Mayo Clinic, "Living Wills and Advance Directives for Medical Decisions," August 02, 2022, <http://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/living-wills/art-20046303>.

This information is necessary to support patient autonomy and to inform patients and their families that they have the right to refuse treatment. This information is critical because as mentioned before, hospice patients and their families are likely overwhelmed and may feel pressured to follow the medical advice given by the hospice. Providing written materials reminding everyone that they have a right to refuse any treatment(s) is important to ensure that patients are always comfortable with the medical decisions that are being made which helps protect their dignity through the dying process.

Adopt subdivision (e)(2)(A)(ii). Subdivision (e)(2)(A)(i) establishes that written materials shall explain how and when submitted advance directives will be implemented. This explanation is necessary to set clear expectations for patients and families and to make sure all patients are fully aware how and when any advance directives they submit will be implemented. Providing this information ahead of time is necessary to promote transparency and manage expectations.

Adopt subdivision (e)(2)(B). Subdivision (e)(2)(A)(i) establishes that advance directive materials shall be provided in the patient's primary language. This requirement is necessary to ensure comprehension and informed decisions and full transparency and proper record keeping. As previously mentioned, providing patients with information about advance directives and making sure they are aware of their rights regarding medical treatments is critical to protect their dignity. This can only be accomplished if the patient is able to fully comprehend the material that is given to them, therefore the hospice has an obligation to provide the materials in the patient's identified primary language. This proposed regulation is necessary to protect the health, safety, and dignity of non-English speaking hospice patients.

Adopt subdivisions (e)(3), (e)(3)(A) and (e)(3)(B). Subdivision (e)(2)(A)(i) establishes that at admission, the hospice shall document whether advance directives were submitted. If directives are submitted, the hospice shall file them and ensure compliance. If not submitted, the hospice shall file signed documentation that the patient received information about advance directives. These actions are necessary to maintain complete records and support enforcement. At the time of admission, a patient or their representative either will or will not submit completed advance directives to the hospice, and the hospice is responsible for recording either scenario. If completed directives are submitted, the hospice must file them accordingly and ensure compliance throughout the patient's services. However, if a patient or their representative does not submit completed advance directives, the hospice must file signed documentation verifying that the patient received information about the availability and benefits of advance directives for future consideration. This proposed regulation is necessary to protect the health and dignity of patients by ensuring hospice agencies educate new patients about the option to provide input or requests about the care they receive.

Adopt subdivision (f). Subdivision (f) establishes that a hospice shall only accept patients whose primary residence is within the hospice's approved service area. "Residence" is a defined term under section 74800(a)(51) therefore "primary residence"

should be reasonably understood by the regulated community. It is necessary to include this distinction because it is not uncommon for terminally ill patients to suddenly relocate and receive their hospice care in a place other than their permanent residence where friends or family are able to provide around-the-clock needed support. Such a relocation could therefore not be considered the patient's "permanent" or "long-term" residence and those terms were discarded due to their restrictive nature. "Primary residence" is the most appropriate selection because it recognizes that individuals may need to move locations, particularly near the end of their life.

This requirement is necessary to ensure patients receive timely nursing care consistent with the two-hour standard in this chapter, specifically the two-hour GSA limitation of section 74820. The Department determined that a patient must be able to receive nursing care within two hours of contacting the hospice and created a detailed model for determining which counties can be serviced within that timeframe. The Department uses this model to approve the service area for each hospice agency upon licensure, therefore, the agency must only accept patients whose primary residence is within this area. A hospice located in Los Angeles, for example, cannot accept a patient whose primary residence is in San Jose because the hospice would not be able to provide nursing care within two hours. This could result in the patient experiencing prolonged and unnecessary suffering. This proposed regulation is necessary to protect the health and safety of patients by ensuring they will be able to receive nursing care within two hours whenever needed.

Adopt section 74864 "Assessments."

Section 74864 establishes standards for initial and comprehensive assessments. This requirement is necessary to establish timely evaluation of newly admitted patients, complete and accurate records for interdisciplinary care, and consistent oversight by the Department. Section 74864 is necessary to fully effectuate the hospice emergency regulations pursuant to HSC section 1753.1 and set clear guidelines for initial and comprehensive assessments. There are currently little to no regulations or guidelines for these assessments under the California Hospice Licensure Act of 1990. HSC section 1749(e) directs hospice agencies to follow the CHAPCA Standards until the Department promulgates regulations.³⁸ The CHAPCA Standards, however, are incomplete and lack clarity. Federal CoPs under Title 42 CFR section 418.54 regulate initial and comprehensive assessments for the patient. The Department is adopting this section mirroring many parts of the federal standards to be aligned. This section is necessary to establish clear and consistent assessment standards for the regulated community to follow and for the Department's surveyors to enforce during oversight actions.

Adopt subdivision (a). Subdivision (a) establishes that a registered nurse must complete an initial assessment within 48 hours of admission. This requirement is necessary to establish timely identification of immediate needs and continuity of care at

³⁸ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

the start of hospice services. Thus, this sets a standard that a new hospice patient must receive an initial assessment by a registered nurse within 48 hours of admission, which is in alignment with federal CoPs under Title 42 CFR section 418.54(a). It is imperative for a hospice agency to quickly evaluate a newly referred patient to identify and address any care, support, or potential concerns that require immediate attention. The people admitted to hospice are in their end-of-life stage, often experiencing high levels of pain or discomfort, therefore any issues that cannot wait for the comprehensive assessment to be completed must be addressed with that timeframe. This proposed regulation is necessary to protect the health and safety of patients by ensuring there are no unnecessary gaps in care between referral and admission to hospice, and that any immediate needs of the patient or the patient's family are quickly identified and addressed.

Adopt subdivision (a)(1). Subdivision (a)(1) requires that the RN assess the patient in the residence where services will be provided and document any safety or environmental issues identified. This requirement is necessary to establish a complete understanding of the care setting for planning and risk mitigation. This requirement is necessary to ensure that the hospice RN assesses the individual in their residence, which is necessary to get a complete picture of the patient's environment where hospice care and services are expected to be provided. If there are any issues, concerns, or fears for the patient's safety identified by the RN during their visit, those would need to be documented in the initial assessment and addressed accordingly to protect the well-being of the patient.

Adopt subdivision (a)(2). Subdivision (a)(2) requires written documentation of initial assessment findings. This requirement is necessary to establish complete and accurate medical records that support interdisciplinary care and Department survey verification. This requirement is necessary to establish the industry standard that admission RNs must document their findings from the initial assessment in writing. This is necessary to ensure that all identified issues get addressed and to ensure hospices maintain complete and accurate medical records for patients which Department surveyors will need to verify compliance with the requirements of this section.

Adopt subdivision (a)(3). Subdivision (a)(3) establishes that the interdisciplinary team must use the initial assessment findings as the basis for developing the plan of care consistent with section 74868. This requirement is necessary to establish a patient specific plan driven by identified needs. This requirement is necessary to establish that the hospice interdisciplinary team must use the findings from a patient's initial assessment as the starting point for developing a personalized plan of care as outlined in further detail under section 74868 "Plan of Care." This is necessary to ensure that all identified issues and concerns from the initial assessment get addressed.

Adopt subdivision (a)(4). Subdivision (a)(4) requires retention of initial assessment documentation consistent with subdivision (a)(2). This requirement is necessary to establish complete records that support care planning and survey review for the same reasons outlined in subdivision (a)(2).

Adopt subdivision (b). Subdivision (b) establishes that hospice employee members of the interdisciplinary team must complete a comprehensive assessment within five days of admission. This requirement is necessary to establish timely development of the plan of care and clarify applicability to hospice employees. This requirement is necessary to establish a standard for the regulated community that the hospice employee members of the interdisciplinary team must complete a patient's comprehensive assessment within five days of admission to hospice, which also aligns with federal CoPs under 42 CFR section 418.54(b). A distinction within the text has been made, however, to differentiate the individuals who are employed by the hospice and are therefore required to adhere to all regulatory requirements. These specific individuals are clearly listed under section 74800, subdivision (a)(31), and are being categorized in the text as the "hospice employee members" of the interdisciplinary team to avoid potential confusion. This distinction is necessary to clarify that the people who have the option to participate in the interdisciplinary team (i.e., the patient's family, representative, and/or caregiver) are not obligated to perform all the same tasks as the hospice employees. While the input and care provided by the optional participants is essential to quality hospice care, it would be unreasonable and inappropriate to require them to perform the same tasks as the hospice employee members, such as writing or reviewing the patient's comprehensive assessment, etc. The Department would also not be able to enforce such a requirement. Newly admitted hospice patients are suffering from a terminal illness, and any delays leaving the individual's condition untreated for an extended period of time could have extremely harmful consequences including increased pain, discomfort, disease progression, or even death. The hospice employee interdisciplinary team members must timely complete a comprehensive assessment because that information is needed to complete a patient's plan of care to begin providing appropriate hospice services to a patient. This proposed regulation is necessary to clarify that these regulations only apply to the hospice employee members of the interdisciplinary team, not patient caregivers or family members. This proposed regulation is also necessary to protect the health and safety of patients by ensuring there are no unnecessary delays in care.

Adopt subdivision (b)(1). Subdivision (b)(1) establishes that the comprehensive assessment must define goals and scope sufficient to guide accurate completion. This requirement is necessary to establish a shared understanding of assessment objectives for consistent practice. This requirement is necessary to promote the patient's well-being, comfort, and dignity throughout the dying process. This regulation provides clarity to the regulated community regarding the goal and purpose of a comprehensive assessment, which is necessary to ensure it is completed accurately.

Adopt subdivision (b)(2). Subdivision (b)(2) establishes that the comprehensive assessment must address the minimum elements required for all patients and document findings to inform the plan of care. This requirement is necessary to establish consistent evaluation, complete records, and appropriate care planning. This requirement is necessary to establish a standard for specific areas of concern that must be taken into consideration when the hospice employee members of interdisciplinary

team complete a patient's comprehensive assessment. Each patient admitted for service will have a unique situation with different experiences, levels of support, medical histories, cognitive abilities, pain tolerance, etc.; therefore, requiring interdisciplinary teams to assess every patient under the same scope helps to ensure no unexpected or unknown issues arise while the patient is receiving hospice care. This proposed regulation is necessary to ensure that hospice interdisciplinary teams thoroughly evaluate every new patient in a similar manner and document their findings so that all personnel providing care to the patient are aware of any potential issues or concerns for the individual. The required information to include in the comprehensive assessment is also necessary for the interdisciplinary team to be able to develop an individualized and appropriate plan of care for the patient.

Adopt subdivisions (b)(2)(A) through (b)(2)(K). Subdivision (b)(2)(A) through (b)(2)(K) establishes the specific considerations the team must review when updating the plan of care. Subdivision (b)(2)(I) establishes that caregiver capacity must be considered when developing a realistic care plan. These requirements are necessary to establish thorough review of the patient's condition and feasible support arrangements during plan of care updates. This requirement is necessary to fully effectuate subdivision (b)(2) and identify specific considerations that the hospice employee members of the interdisciplinary team must review when making any modifications to a patient's current plan of care. This proposed regulation follows current industry practice as seen under Title 42 CFR 418.54 and the CHAPCA Standards in Section 3.1 and is being implemented to ensure critical information related to a patient's condition is thoroughly evaluated during every plan of care review.³⁹ In addition to mirroring these standards, subdivision (b)(2)(I) is added so the interdisciplinary team can develop a more realistic care plan based on how much assistance caregivers and family members are able provide for the patient. Hospice patients are individuals suffering from terminal illnesses, with conditions and symptoms that can change rapidly and unexpectedly. Requiring a patient's care team to regularly monitor and assess the progression of the patient's condition is necessary to ensure the patient is always receiving adequate high-quality care. During all plan of care reviews the team is responsible for re-confirming the patient's functional status, identifying any new potential risks or increases in pain, assessing the caregiver or family's continued willingness and ability to care for the patient, etc. If there are any noticeable changes that have occurred since the previously completed plan of care, the team must develop and propose appropriate modifications.

Adopt subdivisions (b)(3), (b)(3)(A) and (b)(3)(B). Subdivision (b)(3) establishes that policies and procedures must include standardized data elements to measure patient outcomes; (b)(3)(A)–(B) specify how the data must be applied. These requirements are necessary to establish consistent outcome measurement and evaluation of care effectiveness. This requirement is necessary to establish the requirement that hospices must create policies and procedures that use data elements to measure patient

³⁹ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 10, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

outcomes. This is consistent with current standards of practice under Title 42 CFR section 418.54(e)(1) and is necessary to ensure each hospice agency has a clear and consistent way to know whether their patients are receiving appropriate care that is helping to achieve the goals and expectations for the patient as identified in the plan of care.

Adopt subdivision (b)(4). Subdivision (b)(4) requires the comprehensive assessment to be documented and retained in the patient's medical record. This requirement is necessary to establish complete history for clinical decision making and facilitate Department survey verification. This requirement is necessary to ensure the accuracy and integrity of the comprehensive assessment by properly documenting it in the patient's medical record. This is necessary to ensure all members of the hospice interdisciplinary team can see the full history of a patient's condition and hospice experiences thus far, which will help the team make sound judgements and decisions when making updates or modifications to a patient's plan of care. This proposed regulation is also necessary to ensure hospices maintain complete and accurate medical records for all patients, which Department surveyors will need to verify compliance with the requirements of this section.

Adopt subdivisions (c) and (c)(1) through (c)(2). Subdivision (c) establishes that hospice employee members of the interdisciplinary team must review and update the comprehensive assessment at least every 15 days; subdivisions (c)(1)–(c)(2) specify the required updates. This requirement is necessary to establish timely reassessment and prompt adjustments to the plan of care when the patient's condition changes. This requirement is necessary to establish the requirement that the hospice employee members of the interdisciplinary team must review a patient's comprehensive assessment every 15 days at minimum and make any required updates. This proposed regulation aligns with federal CoPs under Title 42 CFR section 418.54(d) and helps to ensure that the needs of the patient are met and addressed appropriately. Hospice patients can experience rapid progression of their condition; therefore, their needs can change quickly. It is therefore imperative for the hospice employee members of the interdisciplinary team to monitor a patient's condition often and be able to adjust in a timely manner, if necessary.

Adopt section 74868 “Plan of Care.”

Section 74868 establishes standards for developing, approving, and updating each patient's plan of care. This requirement is necessary to establish clear responsibilities for hospice personnel, consistent care planning practices, and a scope limited to hospice employee members of the interdisciplinary team (not family caregivers), consistent with referenced cross citations. Section 74868 is necessary to fully effectuate the hospice emergency regulations pursuant to HSC section 1753.1 and set clear guidelines for the care that a hospice must provide to its patients. There are currently little to no regulations or guidelines for developing and executing an acceptable plan of care for patients under the California Hospice Licensure Act of 1990. HSC section 1749(e) directs hospices to follow the CHAPCA Standards until the Department

promulgates regulations.⁴⁰ Sections 3.2 and 3.5 of the CHAPCA Standards are vague and not comprehensive enough to ensure agencies develop thorough and effective plans of care for patients. Similar to the previous sections in article 4, the Department is aligning this section with federal CoPs under the Title 42 CFR section 418.56 which has requirements for the hospice employee members of the interdisciplinary team, care planning, and coordination of service. To provide clarity to the regulated community, it is necessary for the Department to specify that these requirements are only related to the hospice personnel members and not the patient's family members or caregivers if they choose to participate in the interdisciplinary team. These requirements are necessary to ensure consistency among the regulated community and will allow Department surveyors to provide oversight in a consistent manner.

Adopt subdivision (a). Subdivision (a) establishes that a physician must review and approve the medical component of the patient's plan of care. This requirement is necessary to establish clinically appropriate care planning and clear accountability for medical decision making. This requirement is necessary to address all specific concerns and care needs. This requirement aligns with the physician services requirement in the federal CoPs under Title 42 CFR 418.64(a)(3). This proposed regulation is necessary to ensure that the medical component of a patient's plan of care gets reviewed and approved by a physician because no other member of the interdisciplinary team would be qualified to do so, and the risk of providing inappropriate medical management would be detrimental to the health and safety of the patient.

Adopt subdivisions (a)(1), (a)(1)(A) and (a)(1)(B). Subdivision (a)(1) establishes that the plan of care must address patient needs related to the terminal illness and identified family needs associated with care delivery. This requirement is necessary to establish comprehensive, patient specific planning. Subdivision (a)(1)(A) establishes that only hospice employee members of the interdisciplinary team participate in plan of care development and execution; family or caregivers may contribute information but are not subject to personnel requirements. This requirement is necessary to establish the plan of care's scope and responsible parties. Subdivision (a)(1)(B) establishes that hospice employee team members must be trained and qualified for their assigned responsibilities in the plan of care. This requirement is necessary to establish competent care delivery and role clarity. Taken together, the requirements are necessary to ensure all a patient's needs related to their terminal illness are addressed, including the needs of their family members, and that all hospice employee members of the interdisciplinary team are appropriately trained and involved in the development and execution of a patient's plan of care. This proposed regulation is necessary to validate the qualifications of the interdisciplinary team which protects the health and safety of patients. It is also important to clarify that this only applies to the hospice employee members of the interdisciplinary team, not patient caregivers or family members who elect to participate.

⁴⁰ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivisions (a)(2) and (a)(2)(A) through (a)(2)(C). Subdivision (a)(2) establishes that an RN must be assigned as the patient’s case manager. This requirement is necessary to establish accountability for plan of care management. Subdivision (a)(2)(A)–(C) establishes that the RN case manager must: (1) coordinate services among team members; (2) monitor progress against plan of care goals; (3) document and communicate updates to the team and attending physician, as applicable. This requirement is necessary to establish active team coordination and complete communication. These requirements are necessary to clarify to the regulated community that one RN must be assigned to every patient to act as a “case manager” to oversee the management and coordination of services as outlined in a patient’s plan of care, which is in alignment with federal CoPs under Title 42 section CFR section 418.56(a)(1). Identifying one individual as a “case manager” is important to ensure all members of the team are actively participating and meeting the needs of the patient and their family. This proposed regulation is necessary to ensure no part of a patient’s plan of care gets overlooked, which could be detrimental to patient safety.

Adopt subdivision (b). Subdivision (b) establishes that the plan of care must be based on findings from the comprehensive assessment. This requirement is necessary to establish a patient specific plan that addresses identified needs. This requirement is necessary to establish that the hospice employee members of the interdisciplinary team must use the patient’s completed comprehensive assessment as the basis for developing a patient’s plan of care. This requirement is in alignment with Title 42 CFR section 418.56(c) and section 3.2(A) of the CHAPCA Standards.⁴¹ This proposed regulation will ensure that any specific issues or needs identified in the comprehensive assessment do not get overlooked, and that they receive appropriate attention in the development of a patient’s plan of care to ensure those needs get met. This is necessary to protect the health and safety of patients.

Adopt subdivisions (c) and (c)(1) through (c)(19). Subdivision (c) establishes that the interdisciplinary team must create an individualized plan of care for each patient. This requirement is necessary to establish complete documentation of the patient’s condition, assigned responsibilities, measurable goals, and outcomes. Subdivisions (c)(1)–(c)(19) establish the minimum content that must be included in every plan of care. This requirement is necessary to establish consistent care planning and accessible information for all parties involved in care delivery. These requirements are necessary to clarify that a hospice interdisciplinary team must create an individualized plan of care for every patient admitted for service, and to clearly identify what information must be included in the plan of care at minimum. The Department collected and analyzed requirements from federal CoPs under Title 42 CFR section 418.56(c), from Section 3.2 of the CHAPCA Standards, as well as from similar facility types such as HHA regulations in the Title 22 CCR section 74697(b). All the listed requirements

⁴¹ California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Page 10, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

help to portray a patient's overall condition including specific needs or areas of concern, to clearly identify specific responsibilities for certain individuals, and to identify any measurable goals and outcomes for future evaluation. This proposed regulation is necessary to ensure that all significant and relevant information related to a patient is thoroughly documented and easily accessible to all parties involved in the provision of care for that patient.

Adopt subdivisions (d) and (d)(1) through (d)(2). Subdivision (d) establishes that hospice agencies must maintain policies and procedures for interdisciplinary team communication. This requirement is necessary to establish regular, effective communication about a patient's condition and needs. Subdivisions (d)(1)–(d)(2) establish minimum elements for the communication system while permitting agency-specific implementation. This requirement is necessary to establish consistent practices with flexibility for local workflows. These requirements are necessary to specify that hospice agencies must create policies and procedures for their interdisciplinary teams that outline a general system of communication that must be used among the team. This proposed regulation was modeled after a similar concept found in federal CoPs under Title 42 CFR 418.56(e) and in Section 3.5(A) of the CHAPCA Standards.⁴² The Department is aware that a “one size fits all” approach may not always be appropriate and is therefore proposing to allow agencies to determine on their own how best to implement this requirement to meet the needs and communication styles of their personnel. This proposed regulation is necessary to ensure hospice interdisciplinary teams communicate with one another regularly and effectively about the condition and needs of a patient.

Adopt subdivision (e). Subdivision (e) establishes that the assigned RN is responsible for overall management of care and services, including coordination with external providers as indicated in the plan of care. This requirement is necessary to establish clear accountability for care coordination and consistent execution of the plan of care. This requirement is necessary for the same reasons as identified in subdivision (a)(2), and to make clear that the interdisciplinary team's assigned RN is responsible for the overall management of all care and services provided to a patient. This proposed regulation ensures the assigned RN manages care based on the patient's personalized plan of care which must be developed from the findings in that patient's comprehensive assessment as required under subdivision (b). This proposed regulation also requires the assigned RN to coordinate any care and services from providers outside of the hospice. For example, if a patient requires non-basic services such as physical therapy, occupational therapy, or speech-language pathology, it is the responsibility of the assigned RN to ensure all parties involved work together seamlessly. This proposed regulation is necessary to take the stress and burden of organizing care away from hospice patients and their families to allow them a comfortable experience as much as possible during a difficult and emotional time.

⁴² California Hospice and Palliative Care Association, “*Standards of Quality Hospice Care, 2005*,” Page 11, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivision (f). Subdivision (f) establishes that a physician must sign the plan of care to document review and approval. This requirement is necessary to establish clear authorization and enforceable records. This requirement is also necessary for the same reasons described in subdivision (a). Requiring a physician to sign a patient's plan of care validates that it was reviewed and approved by a physician, and the Department surveyors will be able to effectively enforce the requirements of subdivision (a).

Adopt subdivision (g). Subdivision (g) establishes that any change to the plan of care must receive written physician approval and be documented. This requirement is necessary to establish medical oversight of changes and complete records. This regulation is modeled after HHA regulations under the Title 22 CCR section 74697(a)(3), which is a similar entity type to hospice. This requirement is important to ensure the attending physician is kept up to date on the patient's condition. Hospice patients are at risk of experiencing sudden changes to their health and it could be harmful if someone qualified to manage the medical component of patient care (such as a physician) is not consulted to verify that the proposed changes are medically appropriate for the patient. Requiring all approved changes to be documented in writing is equally important for Department surveyors to effectively enforce this requirement. This proposed regulation is necessary to protect the health and safety of patients by ensuring that a qualified medical professional is kept up to date on the status of a patient's condition. It also helps to ensure that a physician has had the opportunity to review and approve proposed modifications to a patient's plan of care to confirm they are appropriate, necessary, and safe to implement.

Adopt subdivision (h). Subdivision (h) establishes that designated individuals with direct patient contact must report any significant change in the patient's condition to the hospice Medical Director (or alternate physician) within 24 hours. This requirement is necessary to establish timely physician notification using a measurable timeframe. This requirement is necessary to establish a new requirement that certain individuals who have direct contact with patients must report significant changes they notice about a patient's condition to the hospice Medical Director, or an alternative physician as described.

This requirement is similar to an existing standard of practice for HHAs under Title 22 CCR section 74697(d) but expanded to include a 24-hour reporting requirement. Significant changes to a hospice patient should be reported immediately upon detection because the sudden change could be a sign of progression of the patient's terminal illness, or a sign of impending death. The term "immediately" however is not a defined term and could be left open to interpretation which would make this regulation difficult to enforce. The Department instead chose to implement the 24-hour requirement which is a measurable amount of time that is as close to the intent of "immediate" without being unreasonable. This is sufficient time for the individual to closely monitor the patient's condition, report any changes to a physician, and make any necessary modifications to the plan of care before the patient is harmed. This proposed regulation is necessary to ensure dying hospice patients receive immediate attention from a qualified medical

professional if there are signs that their condition may be worsening or that the care being provided is no longer adequate and needs adjustment.

Adopt subdivision (i). Subdivision (i) establishes that hospice agencies must maintain policies and procedures describing who must be notified, how to notify, and the required timeframes for reporting significant changes. This requirement is necessary to establish clear notification standards and prevent delays or misrouting. This requirement is necessary to specify that policies and procedures need to be created and made available for the individuals that are required to report a significant change to a patient's condition to follow. Without instructions detailing exactly who to notify, how quickly to notify, and acceptable methods of notification, there is a risk that the report could be submitted too late or to the wrong individuals, which could jeopardize the health and safety of the patient. This proposed regulation is necessary for the same reasons described in subdivision (h) and is also necessary to clarify specific topics and standards that must be addressed in the policies and procedures developed by all hospice agencies.

Adopt subdivisions (i)(1) and (i)(1)(A) through (i)(1)(D). Subdivision (i)(1) establishes examples of significant changes that must be reported, including: (A) sudden loss of coherency; (B) sudden loss of weight or appetite; (C) sudden behavior issues; and (D) sudden increase in pain relative to the patient's baseline. This requirement is necessary to establish a baseline list that agencies must incorporate when defining "significant change." This requirement specifies a few different situations that must be reported if observed including sudden loss of coherency, sudden loss of weight or appetite, sudden behavior issues, or sudden increase in pain which are significantly different than the patient's normal state. These conditions are the most common and troubling issues that a medical professional should be notified about as quickly as possible. These listed situations likely represent a negative shift in the patient's condition or represent impending death, both of which warrant immediate attention. All hospices must use this list as a starting point for developing policies and procedures outlining what must be considered a significant change.

Adopt subdivision (i)(2). Subdivision (i)(2) establishes that policies must specify all required recipients of notification, including clinical personnel (e.g., assigned RN) and, when applicable, the patient's representative or family member. This requirement is necessary to establish prompt involvement of appropriate parties. This requirement is necessary to establish the requirement that a hospice to specifically identify in its policies and procedures the individuals that must be notified of a significant change to a patient's condition in addition to the hospice Medical Director. If any specific hospice personnel such as the assigned RN or spiritual counselors need to quickly get involved to modify the patient's plan of care or provide services, they must be clearly identified on the notification list to ensure the patient gets the appropriate attention. Similarly, a patient's representative or family member may need to quickly get involved to make important medical decisions on behalf of the patient in the event that the patient no longer has the capacity to do so themselves. This proposed regulation is necessary to

identify and clarify who must receive notification of a significant change to ensure the safety and dignity of the patient.

Adopt subdivision (i)(3). Subdivision (i)(3) establishes that notification methods must ensure rapid receipt by required recipients; real time methods (e.g., telephone) are preferred over passive methods (e.g., chart notes) for urgent changes. This requirement is necessary to establish reliable communication in time sensitive situations. This requirement is necessary to clarify how the required individuals under subdivision (i)(2) must be notified. The patient's assigned RN is likely to be notified first because they will be the one to make an immediate judgement of the patient's condition and assess any necessary next steps. The assigned RN should then be contacted as quickly as possible (likely via telephone) to ensure the message is received. Leaving a note for the RN in the patient's medical record, for example, would be insufficient and dangerous in this situation because there is no guarantee the RN would see the note in a timely manner causing an unnecessary delay. This proposed regulation is necessary to ensure the hospice's policies and procedures clearly detail how certain individuals must be notified to ensure they receive the notification quickly enough to be able to help the patient in an emergency.

Adopt subdivision (i)(4). Subdivision (i)(4) establishes that policies must specify timeframes for notifying additional individuals beyond the physician. This requirement is necessary to establish timely responses while allowing agency specific standards. This requirement is necessary to further clarify subdivision (i)(3). Hospices must outline how quickly additional individuals must be notified of a significant change to a patient's condition. Hospices will be able to best determine how quickly these individuals will need to receive notification, based on their role and relationship with the patient. This is necessary to ensure all appropriate people have enough time to respond to the patient's change of condition and care for them accordingly.

Adopt subdivision (i)(5). Subdivision (i)(5) establishes that policies must describe the process for notifying the patient's representative or family of significant changes, including active dying transitions, as appropriate. This requirement is necessary to establish respectful, timely communication supporting patient dignity and family decision making. This requirement is necessary to specify a process and procedure for notifying a patient's representative (or family member) of a significant change. This is an important component for hospices to address to protect the patient's dignity and receive appropriate care. If for example it is found that the patient's condition has transitioned and they are now actively dying, then the hospice will likely want to implement a standard that the patient's representative (or a family member, caregiver, etc.) should be notified immediately to ensure the patient and their loved ones have the opportunity to be together for as long as possible leading up to the patient's final moments of life. This is a very sensitive and emotional experience for both the patient and the patient's representative or family, therefore it is necessary for the hospice to implement clear standards for how personnel should handle these situations to best support everyone involved.

Adopt section 74872 “Plan of Care Review.”

Section 74872 establishes standards for the frequency, responsibility, and required considerations of plan of care reviews. This requirement is necessary to establish consistent review practices, clear accountability for reviewers, and predictable oversight by the Department. Section 74872 is necessary to fully effectuate the hospice emergency regulations pursuant to HSC section 1753.1 and set clear guidelines for how often a patient’s plan of care must be reviewed, who must perform the review, and what considerations must be taken when reviewing. Similar to the “Plan of Care” section, this section is aligned with the Title 42 CFR section 418.56 to reflect current industry practice. Having these regulations in place will create consistency among the regulated community and will also allow Department surveyors to provide oversight in a consistent manner.

Adopt subdivision (a). Subdivision (a) establishes that the hospice interdisciplinary team must review the patient’s plan of care at least every 15 days to confirm it continues to meet the patient’s and family’s needs. This requirement is necessary to establish timely, informed care decisions based on current patient information. This requirement is necessary to establish the requirement that hospice interdisciplinary teams must review a patient’s plan of care at least every 15 days to ensure the plan of care is still meeting the needs of the patient and the patient’s family. Hospice services are intended to promote a hospice patient’s well-being, comfort, and dignity throughout the dying process, and the best way to achieve this goal is to perform frequent checks and assessments of patients and make any required changes as quickly as possible to avoid any unnecessary pain and suffering. This proposed regulation is in alignment with federal CoPs under Title 42 CFR section 418.56(d) and is necessary to ensure that the interdisciplinary team has current information to make quality care decisions and to ensure the patient is as comfortable as possible during the last stage of their life.

Adopt subdivisions (b) and (b)(1) through (b)(3). Subdivision (b) establishes the minimum considerations the hospice employee members of the interdisciplinary team must assess during each plan of care review. This requirement is necessary to establish a consistent, objective basis for determining whether updates are needed. Subdivision (b)(1)–(b)(3) establishes that reviewers must: (1) compare the most recent comprehensive assessment to the current plan of care; (2) evaluate progress toward identified outcomes; (3) reassess symptoms, pain, and other indicators that may require plan of care modifications. This requirement is necessary to establish systematic evaluation of patient status and timely updates to the plan of care. These requirements are necessary to specify the points the hospice employee members of the interdisciplinary team must assess when reviewing a patient’s plan of care. Requiring these members of the interdisciplinary team to compare the most current comprehensive assessment with the patient’s progress toward desired outcomes is in alignment with federal CoPs under Title 42 CFR 418.56(d) and allows the team to accurately and unbiasedly identify whether or not the care being provided to the patient is appropriate. For example, if there is little to no progress being made toward the identified goals, that would be a signal to the interdisciplinary team that adjustments and modifications may be necessary to move in the desired direction. Additionally, if it is

identified in the re-assessment that a patient is experiencing increased pain and discomfort, that would be another signal that a modification is needed. This proposed regulation is necessary for the assigned interdisciplinary team to regularly confirm that the patient is receiving the best possible care, comfort, and dignity through the dying process.

Adopt subdivision (c). Subdivision (c) establishes that the interdisciplinary team must partner with the patient's attending physician during plan of care reviews and document any updates or modifications in writing. This requirement is necessary to establish medical oversight of changes and complete records. This requirement is necessary to ensure the assigned hospice interdisciplinary team works in partnership with the patient's attending physician and documents any updates or modifications in writing. This requirement is in alignment with federal CoPs under Title 42 CFR section 418.56(d) and section 418.64(a)(3). The adoption of this regulation is necessary to ensure that a medical professional qualified to manage the medical component of the patient's care is given an opportunity to review and approve any proposed changes to a plan of care.

Adopt subdivision (d). Subdivision (d) establishes that each completed or updated plan of care must be documented in the patient's medical record. This requirement is necessary to establish a complete history for clinical decision making and Department oversight. This subdivision is necessary to establish the requirement that every completed and updated plan of care must be documented in the patient's medical record. Properly documenting all versions of care provided to a patient is necessary to maintain an accurate and thorough representation of the progression and condition of a patient. This information will be necessary for the interdisciplinary team, or anyone else providing care, to clearly see the patient's history and experience while on hospice and will allow them to make quality decisions based on all the available information.

ADOPT ARTICLE 5 - ADMINISTRATION.

Article 5 establishes administration requirements for hospices to align Title 22 practices and effectuate Health and Safety Code section 1753.1. This requirement is necessary to establish surveyable standards for enforcement by Department staff and ensure consistent application across facility types.

The majority of the proposed regulations in Article 5 codify existing practices and industry standards that are necessary to maintain consistency among all Title 22 facility types. This article contains regulations that are necessary for the Department to meet its statutory obligation under HSC section 1753.1 and are necessary for Department surveyors to enforce the newly promulgated hospice agency regulations.

Adopt section 74876 "Administrator."

Section 74876 establishes Administrator qualifications and limits to comply with Health and Safety Code sections 1753.1(c) and 1753.1(d). This requirement is necessary to establish accountable management, standardized oversight, and surveyable

qualifications for hospice operations. Section 74876 addresses HSC section 1753.1(c) by restricting an Administrator to only managing one hospice agency with the exception for rural areas. It also addresses HSC section 1753.1(d) by setting minimum work experience requirements for hospice Administrators and Administrator Designees, among other requirements.

Adopt subdivision (a). Subdivision (a) requires the governing body to appoint the Administrator in writing. This requirement is necessary to establish clear authority, accountability for day-to-day operations, and surveyable documentation of the appointment. This requirement is necessary to establish a standard that key hospice management personnel such as the Administrator must be selected by the governing body. This is necessary to ensure that the individuals who have responsibility for the operation of the hospice program are aware and confident in the appointment of the program's managers who will carry out the day-to-day duties on behalf of the governing body.

Adopt subdivision (b). Subdivision (b) establishes minimum qualifications for the Administrator and Administrator Designee. An Administrator must meet one of the following pathways: (1) hold appropriate education and have two years of full-time supervisory or managerial experience within the last five years in hospice, home health, or related health care settings; or (2) possess equivalent documented experience that meets the position's duties, consistent with industry standards. This requirement is necessary to establish competent management, reliable oversight, and surveyable qualifications, consistent with Health and Safety Code section 1753.1(d) and aligned with Section 5.1 of the CHAPCA Standards. This requirement is necessary to establish a standard for the minimum experience and qualifications an individual must have to be eligible to be the Administrator or Administrator Designee of a hospice which is necessary to ensure the appointed person is qualified to perform the required functions of the position.

Establishing the minimum education and work experience requirements for a hospice Administrator and Administrator Designee is necessary to ensure the appointed individual is qualified to perform the duties of the position. The Department looked at Section 5.1 of the CHAPCA Standards which only states Administrators must have "supervisory or administrative experience in hospice or related health care fields or education in healthcare or administration that meet the requirements of the position." This language is vague because it does not identify how many years of work experience is appropriate for an Administrator to have.⁴³ For added clarification and to remain consistent among all hospice management personnel positions, the Department implemented the same "two years of full-time supervisory or managerial experience within the last five years" requirement that is being implemented for a hospice DPCS

⁴³ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 13, Last accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

and Medical Director. For more information regarding the justification for two years, please refer to section 74852 (Director of Patient Care Services) subdivision (b)(1).

Subdivision (b) permits qualifying experience from additional health care facility types because Administrators do not provide direct patient care and are not required to hold clinical licensure. This requirement is necessary to expand the candidate pool while maintaining competency, respond to stakeholder concerns about hiring feasibility, and meet the intent of Health and Safety Code section 1753.1(d). Also, like section 74852, the Department is required under HSC section 1753.1(d) to set “hospice specific training and experience” standards for hospice management personnel. However, unlike the DPCS and Medical Director positions, hospice Administrators do not provide care to patients and are not required to hold the same medical professional qualifications. For this reason, it is appropriate to allow experience from additional health care facility types (outside of just hospices or HHAs) to qualify an individual for the position. Allowing this flexibility is necessary because the regulated community has expressed in the past that the work experience requirements were already too limiting. While the Department recognizes it is beneficial to remain consistent among hospice management personnel requirements, expanding the work qualification requirements for Administrators was an opportunity to address stakeholder concerns. This regulation also aligns with the generic “hospice or related health care fields” work experience requirement under the CHAPCA Standards previously mentioned. Because hospice management personnel hold such a high position within the agency with a lot of responsibilities, an Administrator should have the proper education and work experience, not just one or the other. This regulation is necessary to meet the intent of HSC section 1753.1(d) while setting clear and reasonable qualification standards for a hospice Administrator and their Designee.

Adopt subdivision (c). Subdivision (c) requires the hospice to appoint an Administrator Designee who assumes the Administrator’s responsibilities when the Administrator is unavailable. This requirement is necessary to establish continuity of operations, clear points of contact for staff, and surveyable coverage documentation. This requirement is necessary to ensure each hospice has a specific designated individual that can step in and carry out the responsibilities of the position whenever the primary Administrator is unavailable. This appointment is necessary to ensure that whoever is filling in is appropriately qualified and easily identifiable to hospice staff as the next point of contact for any needed assistance.

Adopt subdivision (d). Subdivision (d) requires the Administrator or Administrator Designee to be reachable during their regularly scheduled work hours to provide operational assistance and ensure compliance. This requirement is necessary to establish prompt internal support and consistent oversight during business hours. This requirement is necessary to ensure personnel will be able to reach and receive assistance from either the primary Administrator or the Administrator Designee during their working hours for any reason. Administrators have overall responsibility for day-to-day operations, they also are responsible for ensuring the hospice is compliant with all rules and regulations, and personnel may have a variety of questions throughout the

day that may be time sensitive. Unlike the DPCS and Medical Director who are involved in patient care and must be reachable 24/7, the Administrator position must only be reachable during their regularly scheduled work hours which is consistent with current industry practice as seen in the CHAPCA Standards.

Adopt subdivision (e). Subdivision (e) prohibits appointments as Administrator if disciplinary action has been taken against the individual as described in section 74832, subdivision (b). This requirement is necessary to protect patients and ensure professional management. This requirement is necessary to clarify to the regulated community that a person cannot be appointed Administrator of a hospice if they have had disciplinary action taken against them as outlined in detail under section 74832 (Denial of Application) subdivision (b). This is necessary to protect patients from management who have previously acted in an unprofessional manner.

Adopt subdivision (f). Subdivision (f) requires that an Administrator must manage only one hospice agency, consistent with Health and Safety Code section 1753.1(c). This requirement is necessary to establish adequate managerial focus, prevent diluted oversight, and protect patient safety. This requirement is necessary to establish a standard that an Administrator can only manage and be responsible for one hospice agency. The Department is legislatively required to limit the number of hospices that management staff can be involved with under HSC section 1753.1(c). There is not currently a limit for the number of agencies that hospice management personnel may oversee in the CMS CoPs, the CHAPCA standards, and was not found in any other state regulations. The Title 22 requirements for skilled nursing facilities, however, do limit the number of facilities an Administrator can manage, which is one skilled nursing facility under section 72513(a), with a few listed exceptions.

Subdivision (f) is justified by stakeholder input and Department analysis indicating that multiple agency management risks diminished oversight. This requirement is necessary to ensure proper management and patient focused operations. Based on Department research and stakeholder input, the Administrator should be limited to managing only one hospice agency due to the nature of the roles and responsibilities of the position. The Department is aware that the size and structure of each hospice and the extent of the individual's experience can make a difference in the Administrator's ability to juggle multiple agencies, and the Department desires to ensure that hospice Administrators are not stretched too thin and taking on more than is appropriate. After careful consideration of all recommendations from stakeholders and subject matter experts, the Department determined that an Administrator should be limited to overseeing only one hospice agency to properly manage its agency and provide the best experience for those patients and their families.

Adopt subdivision (g). Subdivision (g) permits an Administrator in a rural area, as defined in Article 1, to manage up to two hospices. This requirement is necessary to address workforce constraints in rural regions while maintaining safe managerial scope. This requirement is necessary to specify a possible exemption to subdivision (f) which would allow Administrators working in a rural area as defined in Article 1 to manage a

total of two hospices. The patient count and daily demand at a rural hospice is likely significantly less than a hospice located in an urban area, therefore it is reasonable to assume that the demands of two rural hospices is equivalent to the demand of one urban hospice. The Department's goal for this regulation was to meet the intent of HSC section 1753.1(c) without being overburdensome to rural agencies that may experience difficulty finding and retaining qualified administrators to serve their remote areas.

Adopt subdivision (h). Subdivision (h) requires a hospice to fill an Administrator vacancy within 60 days. This requirement is necessary to maintain operational continuity and consistency across hospice management positions. When a new Administrator is appointed, the licensee must notify the Department by submitting an application within 10 business days, consistent with section 74828. This requirement is necessary for the same reasons outlined under section 74852 (Director of Patient Care Services) subdivision (h). Sixty days is a reasonable amount of time for hospices to hire a replacement Administrator. This regulation is necessary for consistency among all hospice management personnel. This is also necessary to remain consistent with section 74828 (Report of Changes) which requires that once a new Administrator is appointed, a hospice must notify the Department by submitting an application to the Department within 10 business days pursuant to HSC section 1749(b)(3).

Adopt subdivision (i). Subdivision (i) establishes an extension process for filling the Administrator position when justified. A hospice must: (1) document recruitment efforts and reasons the vacancy could not be filled within 60 days; (2) demonstrate interim management coverage; and (3) show the extended vacancy will not pose a risk to patient health and safety. This requirement is necessary to ensure due diligence and protect patients while providing limited flexibility. This requirement is necessary to specify an extension to subdivision (h), if needed. This is necessary to clarify the specific steps and documentation that is required to qualify for the extension. The Department must be able to ensure that the agency requesting the extension did its due diligence and made reasonable efforts to fill the vacancy prior to approving such a request for consistency. The Department must also be able to determine that the extended vacancy will not pose a risk to the health and safety of patients.

Adopt subdivisions (i)(1) and (i)(1)(A) through (i)(1)(C). Subdivisions (i)(1)(A)–(C) require documentation of: (A) recruitment activities and timelines; (B) interim coverage arrangements; and (C) evidence that patient care and operations remain safe and compliant during the vacancy. This requirement is necessary to establish surveyable evidence supporting an extension request and maintain consistency with section 74852(i). This requirement is necessary for the same reasons identified in section 74852 (Director of Patient Care Services) subdivisions (i)(1) and (i)(1)(A) through (C). The Department implemented the same requirements for the Administrator position to maintain consistency among all hospice management personnel positions.

Adopt subdivision (i)(2). Subdivision (i)(2) requires the hospice to submit a signed attestation that the approved extension will not pose a risk to patient health and safety, describing the mechanisms in place to prevent mismanagement or gaps in care. This

requirement is necessary to ensure enforceable accountability during extended vacancies. This requirement is necessary to establish the requirement that a hospice must submit an attestation that an approved extension for filling the Administrator position will not pose a risk to the health and safety of patients. If this position is vacant for an extended period of time without oversight from a qualified individual it could lead to unintended consequences such as mismanagement or improper care for patients. The hospice must demonstrate it has a mechanism in place to prevent potential harm. This regulation is therefore necessary to protect the health and safety of patients.

Adopt section 74880 “Hospice Management Orientation and Annual Training Requirements.”

Section 74880 establishes minimum orientation, initial training, and annual training standards for hospice management personnel to effectuate HSC section 1753.1(d). This requirement is necessary to establish standardized training content and timelines, consistent implementation across agencies, and surveyable records for Department oversight. Section 74880 was developed by the Department to address HSC section 1753.1(d) which requires minimum standards of hospice-specific orientation and initial/annual training for all hospice management personnel to be established. This section adopts written recommendations received from CHAPCA and other stakeholders regarding appropriate topics to be included and the appropriate amount of time that should be spent discussing the identified topics.

Adopt subdivision (a). Subdivision (a) requires a first-time Administrator or first-time Administrator Designee (an individual newly appointed without prior hospice management experience) to complete certification or training within 12 months of appointment. This requirement is necessary to establish timely competency for safe administrative oversight and consistent application of management standards. This requirement is necessary to ensure that a hospice Administrator or Administrator Designee with limited past work experience receives necessary certification or training to perform the required functions of the position. The Department clarifies to the regulated community that this type of individual is defined as a “first-time Administrator” or a “first-time Administrator Designee.” Stepping into the role of a hospice Administrator comes with a lot of responsibilities that someone with no previous experience may not be prepared for, therefore it is essential to ensure the appointed individual’s knowledge and skillsets are brought up to speed quickly enough to ensure the patients are safe and the hospice agency has appropriate administrative oversight. The Department did extensive research to identify currently available certification and training programs and determined 12 months to be a reasonable amount of time for a new Administrator to register for and complete these requirements. Other timeline options were considered throughout the drafting of this regulation such as 6 months, 18 months, and 24 months, however 6 months is not feasible because the currently available certification exam is not offered frequently enough and 18-24 months starts to put the hospice and its patients at risk by allowing an individual who has not fully proven their competency to manage the hospice for an extended period of time.

Additionally, the Department is allowing first-time Administrators and first-time Administrator Designees to choose from two qualification methods. Stakeholders were supportive of both additional training requirement options for all first-time hospice management personnel, as well as the 12-month timeline to complete them. This regulation is necessary to ensure that the appointed individual is experienced and knowledgeable enough to successfully perform the required duties of the position.

Adopt subdivision (a)(1). Subdivision (a)(1) requires a first-time Administrator who does not pursue certification to complete 24 hours of initial managerial training within 12 months of hire. This requirement is necessary to establish a thorough, time-bound training standard consistent with stakeholder practice. This requirement is necessary to establish a specific number of initial training hours that must be completed by first-time Administrators that choose not to become hospice certified.

As mentioned in the section level summary, stakeholders were actively engaged in the development of this new requirement. The feedback and input that the Department received from leading hospice organizations was that 19-24 hours of initial training for hospice management personnel is current industry practice for most hospice agencies. The Department used this as a starting point for the additional first-time training requirement and suggested 24 hours as the training standard in a stakeholder engagement meeting. The public was supportive of this suggestion. Twenty-four hours of managerial training within 12 months of hire is an appropriate and reasonable requirement for individuals holding such a high-level position within the agency.

Employee training is a basic requirement for any workplace environment. The Department was statutorily required to specify minimum requirements for hospice management personnel, which is necessary to ensure all appointed individuals receive adequate training. This proposed 24-hour training regulation is necessary to ensure that the training standard option is thorough enough to be comparable to the hospice certification program option under subdivision (a)(2). This is intended to ensure that all hospice administrators are as equally qualified as possible while still offering a reasonable alternative for individuals that may not have the time or financial ability to complete a formal certification program

Adopt subdivisions (a)(1)(A) through (a)(1)(E). Subdivisions (a)(1)(A)–(E) identify the core topics a first-time Administrator must cover in training to reflect typical daily responsibilities. This requirement is necessary to establish consistent content across agencies and surveyable training records. This requirement is necessary to establish standardized content because although it can vary depending on the size and structure of a hospice, the listed training topics focus on typical daily roles and responsibilities of a hospice Administrator. Any completed webinar materials used to qualify for an Administrator position should therefore focus on these general topics. This regulation encompasses the core components that should be covered in a first-time Administrator's training materials and is necessary to ensure that everyone who chooses to qualify by completing these webinars focus on the same fundamental topics that are relevant to an Administrator's tasks.

Adopt subdivision (a)(2). Subdivision (a)(2) permits a first-time Administrator or first-time Administrator Designee to qualify by completing a recognized hospice Administrator certification program within 12 months. This requirement is necessary to establish an equivalent pathway to demonstrate competency. This requirement establishes the options for first-time Administrators and first-time Administrator Designees to choose to get formally certified as a hospice Administrator. Becoming hospice certified means they have attained the highest-level standards, skills, and knowledge making them top leaders in the industry. Hospice providers are increasingly recognizing the value that certified hospice management personnel bring to help effectively manage a hospice agency and are therefore beginning to request certification as a condition of employment. The Department is aware that completion of a certification program may be too time consuming and financially burdensome for some individuals, therefore it is not a regulatory requirement but an available option.

Adopt subdivisions (a)(2)(A) through (a)(2)(C). Subdivisions (a)(2)(A)–(C) identify a recognized certification program (NBHHC via CAHSAH) with examination content in (1) business operations; (2) finance; (3) business development; and (4) compliance. This requirement is necessary to establish consistent credentialing standards for first-time Administrators. The Department researched currently available hospice administrator certification programs and the most recognizable examination offered is through the National Board for Home Care and Hospice Certification (NBHHC).⁴⁴ This certification program is offered by California Association for Health Services At Home (CAHSAH) which is a widely-recognized and very credible organization in the industry, and its examination content is made up of four primary topics: business operations, finance, business development, and compliance.⁴⁵ Although it can vary depending on the size and structure of a hospice, this regulation encompasses a hospice Administrator’s typical daily roles and responsibilities. This regulation is necessary to ensure that everyone who chooses to qualify by completing the exam studies the same fundamental topics and is credentialed in a consistent manner.

Adopt subdivisions (b) and (b)(1). Subdivision (b) establishes training requirements for a first-time Medical Director parallel to subdivision (a). These requirements are necessary to establish consistent baseline competencies for patient care oversight for the same reasons described in subdivisions (a) and (a)(1).

Adopt subdivisions (b)(1)(A) through (b)(1)(D). Subdivision (b)(1)(A)–(D) are necessary to establish core clinical and leadership topics aligned with typical day-to-day responsibilities. This requirement is necessary to specify the fundamental concepts that

⁴⁴ National Board for Home Care and Hospice Certification, Last accessed on January 07, 2026, <https://nbhhc.org>.

⁴⁵ NBHHC Certification Candidate Handbook, “*Certified Hospice Administrator Examination Blueprint*,” Page 21, Last accessed January 07, 2026, <https://cdn.ymaws.com/nbhhc.org/resource/resmgr/blueprints/chablueprint.pdf>

a first-time Medical Director must become familiar with to succeed in their position. The listed training topics focus on typical responsibilities and skillsets that a hospice Medical Director is likely to encounter and need daily. The identified topics have a clinical focus, as compared to the topics required for an Administrator for example, because Medical Directors must be equipped to provide ethical medical direction to patients. Any completed webinar materials used to qualify for a Medical Director position should include and focus on these general topics.

Adopt subdivision (b)(2). Subdivision (b)(2) permits a first-time Medical Director to qualify by completing a recognized certification program such as the one offered by the Hospice Medical Director Certification Board (HMDCB). This requirement is necessary for the same reasons described in subdivision (a)(2). This regulation was included upon recommendation from stakeholders. During a November 2023 stakeholder engagement meeting, hospice management personnel work experience requirements were discussed, and many commenters recommended requiring certification for hospice Medical Directors. The Department is aware that completion of a certification program may be too time consuming and financially burdensome for some individuals, therefore it is not a regulatory requirement but an available option.

Adopt subdivisions (b)(2)(A) through (b)(2)(E). Subdivisions (b)(2)(A)–(E) identify the examination content areas: (1) patient and family care; (2) medical knowledge; (3) medical leadership and communication; (4) professionalism; and (5) regulatory compliance and quality improvement. This requirement is necessary to establish consistent credentialing for Medical Directors. The Department researched currently available hospice Medical Director certification programs and found one offered by the HMDCB. This certification program is supported by stakeholders and was recommended to the Department when discussing possible hospice management personnel work requirements in the November 2023 stakeholder engagement meeting. The HMDCB examination content is made up of five primary topics: patient and family care, medical knowledge, medical leadership and communication, professionalism, and regulatory compliance and quality improvement.⁴⁶ The Department incorporated these fundamental principles into the regulation and expanded them a little further for additional clarity.

This regulation encompasses the core components that are likely to be covered in a hospice Medical Director certification exam and is necessary to ensure that everyone who chooses to qualify by completing the exam studies the same fundamental topics and is credentialed in a consistent manner.

Adopt subdivisions (c), (c)(1), (c)(1)(A) through (c)(1)(D) and (c)(2). Subdivision (c) establishes training and optional certification for a first-time Director of Patient Care Services (DPCS) parallel to subdivisions (a) and (b). This requirement is necessary to

⁴⁶ Hospice Medical Director Certification Board, “*Content Blueprint*,” Last accessed on December 10, 2024, <https://hmdcb.org/about-the-exam/default/content-blueprint.html>.

establish consistent credentialing standards for DPCS. This requirement is necessary for the same reasons described in subdivisions (a), (a)(1) and (a)(2). These regulations were implemented and are necessary for consistency among all three hospice management personnel positions. These appointed individuals have the responsibility to properly manage the hospice and should be equally qualified and knowledgeable in their respective fields/specializations.

Adopt subdivisions (c)(2)(A) through (c)(2)(D). Subdivisions (c)(2)(A)–(D) identify recognized certification through the Hospice & Palliative Credentialing Center (HPCC) for experienced RNs, consolidating the examination’s core categories. The Department researched currently available hospice certification programs that would be relevant for a first-time Director of Patient Care Services and found the HPCC which offers different examinations for different nursing levels and titles.⁴⁷ This regulation focused on the Certified Hospice and Palliative Nurse (CHPN) examination, designed for experienced RNs whose resume best aligns with the Director of Patient Care Services work and experience requirements of section 74852 subdivision (b). HPCC’s CHPN exam content consists of five categories which have been consolidated and further clarified upon recommendation from subject matter experts to meet Administrative Procedure Act standards.

This regulation encompasses the core components that are likely to be covered in a hospice Director of Patient Care Services certification exam and is necessary to ensure that everyone who chooses to qualify by completing the exam studies the same fundamental topics and is credentialed in a consistent manner.

Adopt subdivision (d). Subdivision (d) requires newly hired hospice management personnel to complete 20 hours of orientation training within 60 days of hire. This requirement is necessary to establish timely foundational knowledge for safe operations and consistent Department oversight. Personnel already employed before the promulgation of these regulations are not required to complete the new hire training under this subdivision. This requirement is necessary to establish specific initial training requirements that must be completed by all newly hired hospice management personnel. 20 hours of training within the first 60 days was selected based on information provided by stakeholders. Leading hospice organizations informed the Department that 19-24 hours of initial training is the current industry standard for most hospice agencies in California. After careful consideration the Department decided to adopt a requirement for 20 hours of initial training. Twenty hours is reasonable without being overly burdensome since it is already common practice among hospice providers. The Department chose to require the initial training be completed within the first 60 days because it is critical for new management personnel to familiarize themselves with the basic workings and oversight requirements of a hospice as soon as possible upon employment to protect the health and safety of patients.

⁴⁷ Hospice & Palliative Credentialing Center, “*Certification*,” Last Accessed April 15, 2025, <https://www.advancingexpertcare.org/hpcc/>.

It is important to clarify that currently employed hospice management personnel are considered exempted by the Department and therefore not required to meet the new hire training requirements of this subdivision. The Department does not intend to impose overly burdensome training on people that are already sufficiently fulfilling their roles. Directors of Patient Care Services, Medical Directors, and Administrators with many years of experience should not suddenly be required to complete the same training as someone just starting their career.

This regulation is necessary to ensure new hospice management staff receive orientation training on the most fundamental aspects of the operation of a hospice in a reasonable timeframe. Requiring a new manager to complete basic training when starting with a new employer is common practice. Using existing education modules from a leading educational organization in the industry allows hospice agencies to comply without creating an undue burden on the regulated community. It also helps to create clear standards and expectations, allowing Department surveyors to enforce agencies in a consistent and meaningful manner.

In addition to the proposed training modules recommended by stakeholders, the Department added or modified the following requirements for the following reasons:

Subdivision (d)(2)(B): The Department's newly promulgated hospice regulations will be available in this specific chapter of Title 22 and must be reviewed by new hospice management personnel to help ensure they are familiar with all state regulatory requirements to help keep the hospice agency in compliance.

Subdivisions (d)(3)(A)(v) through (d)(3)(A)(vii): These services are listed under "basic services" to align with statute in HSC sections 1749(d)(5), 1749(d)(6) and 1749(d)(7) and ensure the regulated community has clarity regarding the basic services that must be provided by all licensed hospices.

Subdivision (d)(4)(A)(i): Upon recommendation from internal subject matter experts. Risk assessment is an integral part of a proper emergency preparedness plan and should therefore be included.

Subdivision (d)(4)(A)(vi): A hospice must ensure that any emergency preparedness plan it develops meets all necessary and relevant compliance standards to be effective and protect the health and safety of patients.

Subdivision (d)(4)(E)(iv): A federal confidentiality law under Title 42 as identified in the regulation text was added upon recommendation from internal subject matter experts who explained that 25 percent of hospice patients have a substance use disorder (SUD).

Subdivision (d)(4)(E)(v): To include California confidentiality laws in addition to federal (Title 42) laws upon recommendation from internal subject matter

experts. Inclusion of both state and federal requirements provides clarity to the regulated community and will promote compliance and transparency.

Subdivisions (d)(4)(F)(iii) through (d)(4)(F)(v): Upon recommendation from internal subject matter experts. Proper drug administration, especially safe injection practices and any compounded IV products, is critical for the health and safety of patients.

Subdivision (d)(5)(B)(iii): Upon recommendation from internal subject matter experts to ensure management personnel are aware of the patient rights identified in the Act (primarily related to advance directives) to appropriately apply those requirements to their respective agencies.

Adopt subdivisions (e), (e)(1), (e)(1)(A) through (e)(1)(F) and (e)(2). Subdivision (e) requires hospice management personnel to complete 12 hours of annual training, divided as specified in (e)(1)(A)–(F) and (e)(2). This requirement is necessary to establish timely refreshment of core obligations and ensure awareness of any changes to state requirements. It is necessary to establish the requirement that hospice management personnel must complete a yearly refresh of the material discussed during initial orientation which follows stakeholder suggested training modules. Twelve hours was the total recommended amount of time, broken up into two categories as shown in the regulation text, and is a great way to ensure that hospices do not miss any potential changes or amendments to state regulations. The Department also received ample support from stakeholders when this proposed requirement was suggested in a stakeholder engagement meeting. For the justifications on why the identified topics are necessary, please refer to subdivisions (d), (d)(1) and (d)(2).

Adopt subdivision (f). Subdivision (f) clarifies acceptable training/certification formats. This requirement is necessary to establish credible delivery standards and surveyable proof of completion. This requirement is necessary to specify acceptable and appropriate training and certification format options that must be used to meet the requirements of this section. Setting clear guidelines is necessary to ensure the required courses are being provided in a professional setting by credible and reputable sources.

Adopt subdivision (g). Subdivision (g) requires hospice management personnel who begin employment at a new agency to complete that agency's orientation program. This requirement is necessary to establish familiarity with agency specific operations and ensure consistent application of training requirements. This requirement is necessary to prevent individuals from avoiding the training requirements of subdivisions (c) and (d). Each hospice is likely to develop its own training/orientation programs, therefore any time hospice management personnel begin employment at a new agency they should receive the new agency's orientation. This will ensure the individual is fully aware of the new hospice agency's culture, expectations, practices, etc.

Adopt subdivision (h). Subdivision (h) clarifies that a promotion within the same agency does not require repeating the new hire training under subdivision (d). This requirement is necessary to establish proportional training obligations and avoid redundancy. This requirement is necessary to clarify that requiring an individual who receives a promotion within the same hospice agency to repeat the “new hire” training/orientation requirements of subdivision (d) again would be redundant and overly burdensome to both the employee and the hospice agency.

Adopt subdivisions (i) and (i)(1) through (i)(7). Subdivisions (i)(1)–(i)(7) require hospices to maintain specified training/certification records. This requirement is necessary to establish complete documentation for Department verification under HSC section 1753.1(d). This requirement is necessary to codify the industry standard practice for most Title 22 facility types, see HAA regulations under Title 22 CCR section 72517(d) for example. Collecting this identified basic information helps hospices maintain detailed and accurate training and certification records which is essential for Department surveyors to be able to verify the requirements of this section are being met in accordance with HSC section 1753.1(d).

Adopt section 74884 “Personnel Records.”

Section 74884 establishes personnel record requirements for hospices, modeled after Title 22 CCR section 72533(a)(1) with hospice specific additions. This requirement is necessary to establish complete personnel records that support Department oversight and patient safety.

Adopt subdivisions (a). Subdivision (a) requires hospices to maintain personnel records for all employees, contractors, and volunteers. This requirement is necessary to establish complete and accessible information for operational needs and surveyor review.

Adopt subdivisions (b) and (b)(1) through (b)(17). Subdivision (b) requires hospices to include the following in each personnel record, using consistent enumeration and parallel phrasing across items (1) through (17). This requirement is necessary to establish standardized, surveyable records and support timely verification of qualifications and compliance. These requirements are necessary to establish standard industry practice. Nearly all Title 22 facility types collect and maintain this information. This specific list was modeled after skilled nursing facility regulations under Title 22 CCR section 72533(a)(1), with the following additions:

Subdivisions (b)(1), (b)(2), and (b)(3):

Subdivisions (b)(1)–(b)(3) require current contact information to support staffing and dispatch readiness, including on-call personnel. This requirement is necessary to establish timely communication and continuity of patient care.

Subdivisions (b)(8), (b)(9), and (b)(11):

Subdivisions (b)(8), (b)(9), and (b)(11) require records that verify qualifications and completion of orientation and training under section 74880. This requirement

is necessary to establish documented competency consistent with HSC section 1753.1(d) for applicable personnel members. The hospice must complete its due diligence obligations to verify that the individual is properly qualified and must be able to prove that its hospice management personnel completed the requirements found in section 74880 (Hospice Management Orientation and Training).

Subdivision (b)(12). Subdivision (b)(12) requires signed confidentiality and privacy acknowledgments that address Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and hospice policies, retained in the personnel record at hire and renewed at least annually. This requirement is necessary to establish documented accountability for protecting patient and organizational information. This requirement is necessary based upon the recommendation of the Department's internal record subject matter expert (SME). This agreement is related to HIPAA. The signing party (employee, contractor, or volunteer, etc.) attests that they understand they have a legal and ethical responsibility to comply with all requirements of HIPAA, but also that they will maintain the confidentiality, privacy and security of that hospice's patients and families (i.e., comply with hospice specific policies and procedures). Such agreements are executed upon hire after required training has been provided and are renewed annually.

Subdivision (b)(13). Subdivision (b)(13) requires documented screening for federal and state exclusion lists before hire and at a regular, defined frequency during employment, applicable to employees and contractors. This requirement is necessary to establish eligibility verification and prevent prohibited participation. This requirement is necessary based upon the recommendation of the Department's internal record SME and current Medicaid requirements. This requirement is applicable to all personnel and contractors. Screening is necessary to ensure any potential personnel are not on any federal or state exclusion lists. The two main federal databases are List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM). The state level database is the Medi-Cal Exclusion List. The expectation is that all personnel are screened before hire and regularly throughout employment (on a monthly interval, according to the SME) to ensure continued clearance and compliance.

Subdivision (b)(14). Subdivision (b)(14) requires initial and periodic conflict of interest disclosures and related documentation for personnel and contractors. This requirement is necessary to establish transparent records that deter referral kickbacks and billing fraud. This requirement is necessary based upon the recommendation of the Department's internal record SME to initially verify and continually monitor potential conflicts of interest. Such conflicts could include referral kickbacks and billing fraud, which are known issues within the industry nationwide.

Adopt subdivision (c). Subdivision (c) requires hospices to retain personnel records for at least four years after separation. This requirement is necessary to establish available documentation for investigations, audits, and surveyor review. This requirement is necessary to establish the industry standard practice that is consistent with the requirements in place for health facilities to retain records for a set period of time after an employee or contractor separates from the employer. The record retention timeframe varies across jurisdictions and hospice agencies. The Department selected four years based upon recommendation from the internal record SME to align with Gov. Code 12946(a), as enacted by Senate Bill 807 (Wieckowski, Chapter 278, Statutes of 2021), which extended the record retention period from two years to four years for certain California employers, labor organizations, and employment agencies.⁴⁸

Adopt subdivision (d). Subdivision (d) requires personnel records to be completed and organized to permit timely verification by Department surveyors. This requirement is necessary to establish efficient enforcement of hospice regulations. This requirement is necessary for Department surveyors to properly enforce the newly promulgated hospice regulations. This requirement is also in alignment with skilled nursing facility regulations as seen in Title 22 CCR section 72533(b).

Adopt subdivision (e). Subdivision (e) requires hospices to protect personal identifying information in personnel records, including social security numbers, addresses, and medical information, using appropriate confidentiality safeguards. This requirement is necessary to establish privacy protections and prevent unauthorized disclosure. This requirement is necessary to codify the industry standard practice, which is commonly followed by hospice agencies as well as in other workplace contexts.

Adopt subdivision (f). Subdivision (f) requires hospices to make personnel records available to Department surveyors upon request without delay. This requirement is necessary to establish timely access for regulatory oversight by the Department without unnecessary delays or interruption.

Adopt section 74888 “Medical Record Service.”

Section 74888 establishes a medical record service for each hospice to systematically manage patient medical records. This requirement is necessary to establish confidentiality protections, authorized availability of information for care, and surveyable processes for Department oversight.

Adopt subdivision (a). Subdivision (a) requires the hospice to operate a medical record service that manages patient records in a systematic manner. This requirement is necessary to establish confidentiality safeguards and ensure authorized personnel have timely access to information needed for patient care.

Adopt subdivision (b). Subdivision (b) requires the hospice medical record service to perform the listed functions, using consistent enumeration and parallel phrasing. This

⁴⁸ Senate Bill 807 (Wieckowski, Chapter 278, Statutes of 2021)

requirement is necessary to establish standardized processes that protect record integrity, confidentiality, and availability. The required functions and abilities are specified in subdivisions (b)(1) and (b)(2).

Adopt subdivision (b)(1). Subdivision (b)(1) requires a record maintenance system that manages the full lifecycle of medical records: creation; documentation of care; preservation for the required retention period; and secure destruction after the retention period. The system must include privacy and security controls that restrict access and documentation to authorized personnel. This requirement is necessary to establish record integrity and confidentiality across the record lifecycle. The managing process includes creating a medical record, documenting care, preserving medical records for the required retention period, and securely destroying medical records once they are beyond the retention period. This requirement is necessary to protect the integrity of patient health information as the hospice modifies it over the course of time. It is also necessary for the hospice to have a record maintenance system that protects the security of medical record entries so patient health information remains private. Such security protections include, but are not limited to, privacy and security control settings that only enable authorized hospice personnel to document in the medical records. This requirement was modeled after federal CoPs for general acute care hospitals under Title 42 CFR section 482.24(b) and is necessary to adopt for consistency among all Title 22 facility types.

Adopt subdivision (b)(2). Subdivision (b)(2) requires information governance policies and procedures for the medical record service that define standards, processes, roles, and metrics for collecting, analyzing, and protecting patient information, including for electronic health record systems. This requirement is necessary to establish content integrity and security consistent with common industry practice. Information governance encompasses the standards, processes, roles, and metrics for how the medical records service collects, analyzes, and protects patients' medical information. The Department received recommendations from general acute care hospital stakeholders specifying the medical records regulations should require facilities to have information governance policies and procedures, particularly for hospitals with electronic health record systems, to address the integrity of content issues.

This requirement is consistent with common standards of practice recommended by the Department's medical records consultants and is necessary to align hospice regulations with accepted industry standards known to protect the security and maintain the integrity of patient health information. It is also necessary to make hospice regulations consistent with other Title 22 facility type requirements.

Adopt subdivision (c). Subdivision (c) requires documented policies and procedures for the activities identified in subdivisions (c)(1)–(c)(8). This requirement is necessary to establish secure, complete, and organized records that ensure timely access for authorized users and support patient safety.

Adopt subdivisions (c)(1) through (c)(8). Subdivisions (c)(1) through (c)(8) are necessary to establish the list of specific patient medical record activities that must have documented policies and procedures. The activities included in this list are basic practices necessary to properly secure, complete, and organize patient medical records. These regulations are necessary to ensure physicians and other authorized individuals have timely access to patient health information, which helps protect patient safety and ensures quality of care. These regulations are also necessary to make hospice regulations consistent with other Title 22 facility type requirements. The Department would like to further clarify its proposal to:

Adopt subdivision (c)(2)

Subdivision (c)(2) defines reconciliation as the process of comparing entries across the patient's medical record to confirm completeness, accuracy, and internal consistency, and correct identified discrepancies. This requirement is necessary to establish reliable, error-free records. This subdivision is necessary to establish that each patient has a detailed and accurate medical record and allows hospice personnel to provide safe and effective care for patients. It also helps to ensure the integrity of a patient's medical record, including their confidential patient health information, is complete and accurate. Reconciliation is an industry standard term and is necessary to reflect current industry practices.

Adopt subdivision (c)(3)

Subdivision (c)(3) defines deficiency analysis as the review of the medical record to identify missing, incomplete, or inaccurate elements and to document corrective actions. This requirement is necessary to establish complete and accurate patient records that support safe care. This requirement is necessary to specify the tool used to ensure that every patient's medical record contains accurate information, because inaccurate or missing information in a patient's record could negatively affect the health and safety of patients. Deficiency analysis is common industry practice and necessary to promote patient safety.

Adopt subdivisions (d), (e), and (e)(1) through (e)(4). Subdivisions (d) and (e) require medical records to be available at all times to authorized personnel and the Department, with procedures that ensure timely access for care and unannounced surveys. This requirement is necessary to establish continuous availability and survey readiness. Hospice patients suffer from terminal illnesses that can progress rapidly. Therefore, hospice services are provided 24 hours a day, seven days a week as needed. The ability to access a patient's medical record is essential for hospice personnel to be able to provide proper care to patients at any time of the day. Patient medical records must be available and accessible at all times to respond to medical requests and unannounced Department surveys in a timely manner.

Adopt subdivision (f). Subdivision (f) requires compliance with patient rights to inspect, obtain, and amend medical records as specified in HSC sections 123110 and 123111 and Title 45 CFR sections 164.524 and 164.526. This requirement is necessary to establish consistent processes for patient access and amendments. This requirement

is necessary to establish that a hospice's medical records service must follow the identified laws governing a patient's right to obtain and inspect their medical records. HSC section 123110 provides patients the right to inspect and obtain copies of their medical records, and HSC section 123111 provides patients the right to provide addendums to their medical record. Title 45 CFR section 164.524 provide patients access to their protected health information and section 164.526 provides patients the right to amend protected health information or a specific medical record, as discussed in subdivision (e)(3). This requirement is reasonably necessary to align with current industry standards intended to protect patient medical records. The Department cross-referenced these specific laws in the text for convenience and clarity to the regulated community and to emphasize their importance in relation to the privacy rules in this regulation. The reference is not intended to supplant the federal rules. This proposed regulation was intended to prevent hospice patients from experiencing any difficulty obtaining or requesting corrections to their medical records.

Adopt subdivision (f)(1). Subdivision (f)(1) requires medical record copies to be transmitted within 15 days of receiving the request, consistent with HSC section 123110(b) as mentioned above. Identifying this specific statute directly into the regulations is necessary to ensure licensees are aware of and have the full picture of what they must comply with. It is also necessary to make sure make sure patients receive timely responses to their requests and create consistency among all Title 22 facility types.

Adopt subdivisions (f)(2), and (f)(2)(A) through (f)(2)(C). Subdivision (f)(2) requires written methods for receiving, processing, and fulfilling patient requests, including criteria to determine eligibility or ineligibility, as specified in (f)(2)(A)–(C). This requirement is necessary to establish consistent, equitable responses to requests. This requirement is necessary to establish the industry standard practice to adopt clear and systematic methods that detail how and when hospices must respond to patient medical requests, including how to determine if a request is eligible or ineligible, is necessary to ensure patients are responded to equitably and with the highest level of service.

Adopt subdivision (f)(3). Subdivision (f)(3) requires documentation of all patient requests, actions taken, and reasons for any denial, and requires the hospice to notify the patient of its decision by a reasonable communication method (e.g., phone, email, or mail). This requirement is necessary to establish transparent records and protect the integrity of patient information. This requirement is necessary to establish that a hospice's medical records service documents all patient requests for access to their medical records, including the justification any time a record request is denied by the hospice. A medical records service will typically call, e-mail, or send a letter by mail to notify the patient of the hospice's decision and state the reason(s) why the request was accepted or denied in the patient's medical record. This industry standard practice protects the integrity of the patient's health information.

Adopt subdivision (g). Subdivision (g) requires the medical record service to comply with applicable state and federal laws governing the protection and disposal of medical

records and to apply the retention requirements specified in section 74896(b). This requirement is necessary to establish consistent retention and disposal practices that prevent improper handling of records. This requirement is necessary to establish consistency among other regulations within the Title 22 facility types, and for the reasons described previously in "changes common to all sections." This is also necessary to ensure hospice regulations conform to state and federal laws designed to protect patients' health information and prevent data breaches that can result in improper disposal or destruction of patient medical records. For clarification and justification for the hospice retention requirement, please refer to section 74896 (Medical Record Use and Access) subdivision (b).

Adopt subdivision (h). Subdivision (h) requires the hospice to obtain a certificate of destruction from its contracted shredding or disposal vendor verifying complete destruction of medical records. This requirement is necessary to establish verifiable disposal practices that protect the security and integrity of patient health information. General acute care hospitals are required under HIPAA to procure a certificate of destruction from its contracted shredding company to verify a thorough destruction of the requested medical records took place. This requirement is necessary to align hospice regulations with current laws, industry standards-of-practice known to protect the security and integrity of patient health information, and other Title 22 facility types.

Adopt subdivision (i). Subdivision (i) requires immediate notification to the Department if the retention requirement under section 74896(b) is not met. This requirement is necessary to establish prompt oversight and corrective action consistent with CHAPCA Section 6.3(B)(3)(f). The improper or untimely destruction of medical records is a serious offense that could have a negative impact on a patient's ability to receive proper care or prohibit them from accessing pertinent information. This requirement is consistent with Section 6.3(B)(3)(f) of the CHAPCA Standards which states the Department must be immediately notified in this situation and provides the Department with the opportunity to intervene in the situation as quickly as possible to instruct, educate, or sanction the hospice, if necessary.

Adopt section 74892 "Medical Record Content."

Section 74892 establishes the minimum content for each hospice patient's medical record, whether hardcopy or electronic. This requirement is necessary to establish standardized documentation, complete clinical histories, and surveyable records for Department oversight. Medical records are industry standard practice and a vital tool for capturing the history of patient care. This section was modeled after a variety of sources including Section 6.3(B)(1) of the CHAPCA Standards, federal Condition of Participation under Title 42 CFR section 418.104 subdivisions (a) and (e), HHA regulations in Title 22 CCR section 74735(a)(1), as well as other similarly related Department regulations to ensure consistency in enforcement. This proposed regulation is necessary to ensure that hospices create a unique medical record for every patient receiving services, and that they maintain it the same way, regardless of the record type (hard-copy or electronic).

Adopt subdivision (a). Subdivision (a) requires the admission record to include the listed identifying and contextual information. This requirement is necessary to establish complete documentation and ensure key information is readily available for care. Subdivisions (a)(1) through (a)(17) are necessary to establish each required element in the admission record.

Subdivisions (a)(1)–(a)(4) require legal name, home address, date of birth (and age), Social Security number, and one additional identifier to verify identity and prevent record mismatch. This requirement is necessary to establish accurate patient identification and protect against documentation errors.

Adopt subdivisions (a)(1) and (a)(2). Subdivisions (a)(1) and (a)(2) establish the requirement that the hospice enter the patient’s legal name and home address or current place of residence in the medical record. These subdivisions are necessary to establish industry standard consistent with the existing requirement in the CHAPCA Standards. This basic information is necessary for any medical entity providing services to have on file for a patient. A legal name is required for proof of identity and accurate billing, and a home address is especially important because hospice services are provided to patients at home and the medical care team must know where to go.

Adopt subdivision (a)(3). Subdivision (a)(3) is necessary to establish the requirement that the hospice document the patient’s age and date of birth in the medical record. This requirement is necessary to establish multiple ways to verify a patient’s identity, and their age to provide the most appropriate care. If a patient’s date of birth is entered in their medical record incorrectly, the patient’s age serves as a backup to verify how old the patient is. Alternatively, in the event the hospice has more than one patient with the same legal name, the date of birth can be used to properly identify the individual. This is necessary to ensure proper medical record documentation and prevent patient harm.

Adopt subdivisions (a)(4) and (a)(4)(A) through (C). Subdivision (a)(4) is necessary to establish the requirement that the hospice document the patient’s social security number or individual taxpayer identification and one additional number in the medical record for additional identification verification. This requirement establishes that the additional identification verification information includes (A) A unique patient identification number created by the hospice, (B) A Medicare number, or (C) A Medicaid number. Documentation of a patient’s social security number is necessary for proper identification of patients, and one additional source of identification is required as a back-up and/or alternative source of identification. The additional identification number is a data element recorded in the medical record and is used to prevent medical record mismatch errors that could cause patient harm. This regulation is necessary to align with current industry standards known to protect the integrity of a patient’s medical record and to promote patient safety.

Subdivisions (a)(5)–(a)(7) require documentation of biological sex, gender identity, and—if provided—sexual orientation. This requirement is necessary to establish

respectful, individualized care, ensure appropriate clinical considerations, and maintain accurate records consistent with current standards and applicable law.

Adopt subdivision (a)(5). Subdivision (a)(5) is necessary to establish the requirement that the hospice enter the patient's biological sex assigned at birth in the medical record. While subdivision (a)(6) below identifies the patient's current gender identity information, the patient's biological sex could differ and may require consideration by hospice personnel when determining appropriate care. This requirement is necessary for medical professionals to have a full picture of the patient's biological needs to provide the best possible care.

Adopt subdivision (a)(6). Subdivision (a)(6) is necessary to establish the requirement that the hospice enter the patient's gender identity in the medical record, if available. This requirement is necessary because gender identity is not always the same as the patient's biologic sex, or the sex assigned at birth, as is the case for any transgender and nonbinary patients. Documenting the patient's gender identity helps protect patient's rights by ensuring hospice personnel address the patient by the correct pronouns and gender with which they identify. Correctly documenting a patient's preferred gender identity is also beneficial for the health and safety of the patient as transgender and nonbinary patients may have special medical needs. Furthermore, this requirement helps to protect the patient's dignity through the dying process and aligns with California's Gender Recognition Act, which creates a nonbinary gender category on California birth certificates, drivers' licenses, identity cards, and gender-court orders. Lastly, this requirement is necessary to remain consistent with other Department regulations. For example, GACH stakeholders recommended for the Department to include gender identity in a patient's medical record as a separate data element from the individual's sex assigned at birth.

Adopt subdivision (a)(7). Subdivision (a)(7) is necessary to establish the requirement that the hospice enter the patient's sexual orientation in the medical record, if available. This requirement is necessary to align with current standards of practice designed to protect patients' rights and to acknowledge the unique role sexual orientation may play in a patient's individual health needs. It is important for hospices to document and acknowledge the sexual orientation (and gender identity) of Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals to ensure that the needs of this specific population are not overlooked by their healthcare providers. Requiring hospices to collect sexual orientation and gender identity information is necessary to provide any specific care necessary to increase the quality of care for LGBT hospice patients and protect their dignity through the dying process. This information is only required to be documented if the patient or their representative provides it, which protects the patient's privacy rights.

Subdivisions (a)(8)–(a)(10) require documentation of marital or registered domestic partnership status, religious preference (if applicable), and preferred language/communication needs. This requirement is necessary to establish accurate context for care coordination, appropriate spiritual/bereavement services, and effective communication with the patient and family.

Adopt subdivision (a)(8). Subdivision (a)(8) is necessary to establish the requirement that the hospice enter the patient's marital or registered domestic partner status in the medical record. This requirement is necessary to clarify to the regulated community that a hospice must document a patient's marital or registered domestic partnership status to reflect terminology and practices consistent with those currently used in the industry.

Adopt subdivision (a)(9). Subdivision (a)(9) is necessary to establish the requirement that the hospice enter the patient's religious preference in the medical record if available. This requirement is necessary to clarify to the regulated community that a hospice must document a patient's religious preference, if applicable, which includes any specific religious affiliation. The Department broadened the language to be inclusive of patients who may or may not have a recognized religious affiliation. Hospice personnel must be aware of a patient's religious preference in case a type of medication or practice goes against the patient's religious beliefs. Additionally, this information is necessary for the hospice to provide appropriate spiritual and bereavement services to the patient and the patient's family. This regulation modernizes the terminology consistent with terms currently used by the regulated community and is necessary to enhance proper medical record documentation and allow hospice personnel to provide appropriate care and services to patients.

Adopt subdivision (a)(10). Subdivision (a)(10) is necessary to establish the requirement that the hospice enter the patient's language preference in the medical record. This requirement is necessary to ensure the hospice is able to properly communicate and confirm that the patient is aware of, and consents to, the care and services being provided. This information is also necessary to determine if translation services are necessary, thereby ensuring non-English speaking patients are able to understand their hospice care providers and receive appropriate and effective care.

Adopt subdivision (a)(11). Subdivision (a)(11) is necessary to establish the requirement that the hospice enter the patient's date of admission in the medical record. This requirement is necessary to establish accurate billing and enforcement review and to maintain a complete clinical timeline. This requirement is necessary to align with current practice under the CHAPCA Standards and for accurate record keeping. Knowing when the patient started receiving hospice care is necessary for billing and enforcement purposes. For example, if a terminally ill patient has been receiving care for longer than 12 months, which is the maximum anticipated lifespan for hospice patients according to HSC section 1746(p), that may be an indication of potential fraud. This proposed regulation is necessary to maintain complete and accurate medical information for every patient and is helpful to combat fraudulent activity.

Adopt subdivision (a)(12). Subdivision (a)(12) is necessary to establish the requirement that the hospice enter the patient's reason for admission in the medical record. This requirement is necessary to establish clear care rationale and inform clinical decision-making. This requirement is necessary to ensure all hospice personnel

are aware of the patient's condition and can therefore suggest specific and appropriate care recommendations.

Adopt subdivision (a)(13). Subdivision (a)(13) is necessary to establish the requirement that the hospice enter the patient's source of referral in the medical record. This requirement is necessary to establish contact for additional information and support oversight of referral practices. This requirement is necessary to align with industry standard practice under the CHAPCA Standards. Knowing the source of referral is helpful in the event the hospice agency needs additional information about the patient and/or their condition. This requirement is necessary to help combat future fraud. Referral "kickbacks" have been an issue within the industry; therefore, recording the source of referrals will be beneficial in the event of a complaint or investigation.

Adopt subdivision (a)(14). Subdivision (a)(14) is necessary to establish the requirement that the hospice enter the patient's date of discharge or transfer from the referring facility in the medical record, if available. This requirement is necessary to establish continuity and a complete care history. This requirement is necessary to align with current practice under the CHAPCA Standards and for accurate record keeping. This will ensure the patient's full hospice experience is properly accounted for.

Adopt subdivisions (a)(15) and (a)(15)(A). Subdivision (a)(15)(A) is necessary to establish the requirement that the hospice enter the patient's attending physician contact information in the medical record. This requirement is necessary to establish timely coordination and clear points of contact. This requirement is necessary to align with current practice under the CHAPCA Standards. It is necessary for this basic contact information to be kept in the medical record to ensure hospice personnel can reach the patient's attending physician when necessary. The attending physician is consulted several times throughout the patient's receipt of hospice care therefore having current contact information on file is essential.

Adopt subdivision (a)(15)(B). Subdivision (a)(15)(B) is necessary to establish the requirement that the hospice enter the patient's representative contact information in the medical record. This requirement is necessary to ensure the hospice agency has contact information for all parties involved with the patient. For example, the caregiver is the person assisting the patient day-to-day so the hospice needs their contact information to be able to coordinate visits, but the person who must be notified of an emergency or death could be someone different. The hospice should therefore have contact information for those people associated with the patient's care.

Adopt subdivision (a)(15)(C). Subdivision (a)(15)(C) is necessary to establish the requirement that the hospice enter the patient's representative emergency contact information in the medical record. This requirement is necessary to align with industry standard practice under the CHAPCA Standards, and for the reasons identified in subdivision (a)(15)(B) above.

Adopt subdivision (a)(16). Subdivision (a)(16) is necessary to establish the requirement that the hospice enter the patient's informed consent, authorization, and election of hospice care forms in the medical record. This requirement is necessary to establish informed consent and ensure comprehension of hospice services. This requirement is necessary to incorporate the federal election of hospice care requirements under Title 42 CFR 418.24, which require a hospice to confirm that the patient is aware of and approves the decision to begin receiving hospice services. A signature serves as confirmation that the identified forms were received and approved by the patient. Making the information available in the patient's preferred language ensures the individual's comprehension of the material and protects their overall health and safety.

Adopt subdivision (a)(17). Subdivision (a)(17) is necessary to establish the requirement that the hospice enter the patient's advance directives notice in the medical record. This requirement is necessary to establish patient awareness and maintain surveyable evidence of compliance. This requirement goes beyond the Section 6.3(B)(1)(a)(12) of the CHAPCA Standards, which lists advance directives as a requirement for a hospice admission record "if available." However, it is very vague and unclear. This regulation is necessary to clarify to the regulated community the specific steps and actions that the hospice must take regarding advance directives whenever admitting a patient. The Department intends this requirement to align with federal CoPs under Title 42 CFR 418.104(a)(6) stating, "the hospice must inform and distribute written information to the patient concerning its policies on advance directives." This regulation is necessary to clarify to the regulated community that even if a patient does not have completed advance directives at the time of admission to hospice, the hospice must provide written information in the patient's preferred language to ensure the patient is made aware of this option and the benefits of choosing to complete them. This language is also consistent with the requirements of section 74860 (Admission) subdivisions (e)(2) and (e)(3)(B), however the requirements of this section make it mandatory for the documentation/written information regarding advance directives to be filed in the patient's medical record.

Adopt subdivision (b). Subdivision (b) is necessary to establish the requirement that the hospice enter the patient's initial certification of terminal illness in the medical record. This requirement is necessary to establish eligibility and verify the need for hospice services. This requirement is necessary to establish industry standard practice. This information is already being collected and stored in the medical record under both Title 42 CFR section 418.104 subdivision (a)(5) as well as the CHAPCA Standards. The Department surveyors must have access to this document to verify the patient's condition and need for hospice care.

Adopt subdivision (c). Subdivision (c) is necessary to establish the requirement that the hospice enter the patient's initial assessment in the medical record. This requirement is necessary to establish complete assessment histories for each patient. This requirement is necessary to incorporate standards from the federal CoPs under Title 42 CFR section 418.104(a)(1). The Department included a cross-reference

directing the regulated community to section 74864 (Assessments) subdivision (a) which specifically outlines all information related to a patient's initial assessment that must be filed in the medical record. This regulation is necessary to ensure a full and complete medical record is maintained for each patient.

Adopt subdivision (d). Subdivision (d) is necessary to establish the requirement that the hospice enter the patient's initial comprehensive assessment in the medical record. This requirement is necessary to establish complete assessment histories for each patient. This requirement is necessary for the same reason as subdivision (c). The Department added relevant cross-references to section 74864 (Assessments) subdivisions (b) and (c) which specifically outline all information related to a patient's initial and subsequent comprehensive assessments for the entirety of a patient's hospice experience.

Adopt subdivision (e). Subdivision (e) is necessary to establish the requirement that the hospice enter the patient's diagnosis, condition, and other health information in the medical record. This requirement is necessary to establish clinical context for individualized plans of care. This requirement is necessary to align with the CHAPCA Standards and HHA regs identified in the section level summary. This requirement is necessary to identify and record the patient's specific condition, in addition to a certification of terminal illness, to ensure hospice personnel have all relevant information to properly care for the patient. This will help them create a plan of care that is individualized and specific to every patient.

Adopt subdivision (f). Subdivision (f) is necessary to establish the requirement that the hospice enter the patient's initial and subsequent plans of care in the medical record. This requirement is necessary to establish complete care histories and clear points of contact. This requirement is necessary for the same reason as subdivision (c). The Department added relevant cross-references to section 74868 (Plan of Care) subdivision (c) which outlines everything that must be included in a patient's initial plan of care, and to section 74872 (Plan of Care – Review) which discusses the requirements for all subsequent and updated plans of care. Complete and accurate records of all plans of care developed for a patient must be included so that hospice physicians and other personnel providing care may review the patient's overall medical history and make sound clinical decisions. This information is also critical for determining the progression of a patient's terminal illness, for determining appropriate care goals, and measuring other health markers. Additionally, the authors, SMEs, and personnel involved in developing each assessment must be documented in the patient's medical record. This is necessary for hospice personnel and Department surveyors to easily identify a point of contact for questions or concerns regarding any past care provided to the patient.

Adopt subdivision (g). Subdivision (g) is necessary to establish the requirement that the hospice enter the patient's physician's consultation reports, orders, and progress notes in the medical record. This requirement is necessary to establish progress tracking and comprehensive clinical monitoring. This requirement is necessary to

establish industry standard practice. It is critical to document any encounters, observations, and recommendations made by a physician regarding the patient's condition to track their progress. It is also necessary to maintain a complete and accurate medical record.

Adopt subdivision (h). Subdivision (h) is necessary to establish the requirement that the hospice enter the patient's history and physical exams in the medical record. This requirement is necessary to establish progress tracking and comprehensive clinical monitoring. This requirement is necessary to properly track the progress of the patient's condition. A physical exam before initiating services will give personnel a baseline to compare against all future exams. This is necessary to ensure the patient's condition is thoroughly monitored and recorded while receiving hospice services, and that any new diagnoses are identified and properly addressed.

Adopt subdivision (i). Subdivision (i) is necessary to establish the requirement that the hospice enter the patient's reports of laboratory and imaging tests in the medical record. This requirement is necessary to establish a complete and accurate medical record. This requirement is necessary to establish industry standard practice. Including this information is necessary to maintain a complete and accurate medical record. This requirement is necessary to incorporate the CHAPCA Standards and the HHA regs identified in the section level summary.

Adopt subdivision (j). Subdivision (j) is necessary to establish the requirement that the hospice enter the patient's list of prescribed medications and written instructions for use of each in the medical record. This requirement is necessary to establish complete medication history, authenticated entries, and patient safety oversight. This requirement is necessary to establish industry standard practice. Recording all prescribed medications (including instructions for usage) is critical to protect the health and safety of patients. Every person providing direct care to the patient should be able to access this information in the medical record to ensure the whole interdisciplinary team is on the same page, and to ensure proper care is being provided. This is necessary to protect patients from risk of dangerous side effects including overdose or death.

Adopt subdivision (k). Subdivision (k) is necessary to establish the requirement that the hospice enter the patient's medication administration records in the medical record. This requirement is necessary to establish complete medication histories, authenticated entries, and patient safety oversight. This requirement is necessary because medication administration is a critical part of providing hospice care to terminally ill patients. The Department modeled these requirements after current standard of practice as seen in Section 6.3(B)(1)(a)(9)(d) of the CHAPCA Standards with the following additions for enhanced medical record documentation.⁴⁹

⁴⁹ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 20, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

Adopt subdivision (k)(4) to accurately record the specific personnel member that performed each administration. This is necessary for other hospice personnel and Department surveyors to easily identify a point of contact for questions or concerns regarding a medication dosage given to the patient at any time. This requirement is also in alignment with federal CoPs under Title 42 CFR section 418.104(b) which requires all entries to be appropriately authenticated.

Adopt subdivision (k)(6) to ensure a patient's assigned RN is aware of any negative experience/reaction to a medication. It would be dangerous for hospice personnel to continue to administer a medication to which the patient does not respond well; therefore, it is necessary for the RN to be able to quickly consult with a hospice physician (or other medical professionals) and implement necessary changes to better protect and care for the patient. It is also important for hospices to document this information in the event the Department receives a complaint and must investigate the situation. Surveyors would need to be able to easily access all detailed information about the reported event from the patient's medical record to complete their duties. This regulation is necessary to assist the Department surveyors with proper enforcement/complaint investigation, to ensure patients receive effective care, and to promote overall patient health and safety.

Adopt subdivision (k)(7) to capture any medications that were intentionally or unintentionally not administered to the patient. Regardless of the reason, the patient's medical record should accurately reflect these events for their care team to note and review. It could result in the need for a change of the patient's medication type, dosage, or a need for the hospice personnel to take additional/corrective training. This regulation is necessary to ensure hospices maintain thorough and detailed documentation and records of a patient's medication administration history by hospice personnel for the health and safety of every patient.

Adopt subdivision (l). Subdivision (l) is necessary to establish the requirement that the hospice enter the patient's treatment orders, dietary orders, and orders for therapeutic and other program services in the medical record. This requirement is necessary to establish complete care histories and support safe, coordinated treatment. This requirement is necessary to establish industry standard practice. Recording this information is necessary to ensure the whole interdisciplinary team is on the same page so that patients receive the proper care as required for their individual conditions. This proposed regulation helps to protect the health and safety of patients.

Adopt subdivision (m). Subdivision (m) is necessary to establish the requirement that the hospice enter the patient's food and drug allergy information in the medical record. This requirement is necessary to establish complete care histories and support safe, coordinated treatment. This requirement is necessary for the same reasons as subdivision (l) above. This information must be easily identifiable within the record to prevent any allergic reactions and unnecessary suffering for the patient.

Adopt subdivision (n). Subdivision (n) is necessary to establish the requirement that the hospice enter the patient's medical supplies, appliances, or special devices in the medical record. This requirement is necessary to establish complete care histories and support safe, coordinated treatment. This requirement is necessary to incorporate the industry standard practice under the CHAPCA Standards. This is necessary to ensure the patient receives the best quality care.

Adopt subdivisions (o) and (o)(1) through (3). Subdivision (o) is necessary to establish the requirement that the hospice enter the patient's interdisciplinary team meeting notes in the medical record. This requirement is necessary to establish clear care histories and support clinical and surveyor review. This requirement is necessary to promote transparency from a patient's hospice interdisciplinary team regarding the discussions and decisions made for that individual's care. The required basic information, along with a summary of the meeting, is necessary to document and maintain a thorough and detailed medical record for each patient. Any member of the interdisciplinary team (or other hospice personnel member) would be able to refer to any meeting notes if they needed to recall a decision that was made, any alternative care suggestions, identify any past issues the patient and their team experienced, etc. It will also be critical for Department surveyors to have a clear picture of the patient's care journey/experience and identify specific personnel that were involved if they need to contact them for any reason. This regulation is necessary to ensure hospices maintain thorough and detailed records of a patient's hospice care history to protect the overall health and safety of every patient.

Adopt subdivisions (p) and (p)(1) through (p)(3). Subdivision (p) is necessary to establish the requirement that the hospice enter the patient's clinical notes in the medical record. This requirement is necessary to establish progress tracking and timely care adjustments. This requirement is necessary for the same reasons identified in subdivision (l). Detailed clinical notes from each visit with the patient are necessary to monitor the progress of the patient's condition, are necessary to maintain a complete medical record, and also align with current practice under the CHAPCA Standards.

Adopt subdivision (q). Subdivision (q) is necessary to establish the requirement that the hospice enter the patient's documentation recording notifications of a significant change in the patient's condition to all required individuals in the medical record. This requirement is necessary to establish progress tracking and timely care adjustments. This requirement is necessary to ensure that the requirement to notify and document significant changes to a patient's condition under section 74868 (Plan of Care) subdivision (h) is appropriately documented in the patient's medical record. Such changes could be minor and easily remedied, or they could signal that the patient's final stage of life is near which may require additional attention and/or different care. This information may also be important to have on record in the event of a complaint or Department survey.

This regulation is similar to the requirement under Section 6.3(B)(1)(a)(9)(b) of the CHAPCA Standards which states “a record of pertinent observations” must be included in the medical record and is necessary to maintain accurate and thorough records of the patient’s health journey.

Adopt subdivision (r). Subdivision (r) is necessary to establish the requirement that the hospice enter the patient’s documentation of written instructions regarding disposal of controlled substances provided to the family in the medical record. This requirement is necessary to establish safe medication practices and prevent misuse or harm. This requirement is also necessary to ensure any prescribed controlled substances that are in possession of the patient or the patient’s family are always properly stored and handled. A signature is required as confirmation of the patient and patient’s family’s full understanding of the instructions and expectations discussed. This is a necessary precaution to help prevent controlled substances from being mishandled, lost, or administered incorrectly which could result in patient harm. Additionally, confirmation that the controlled substances will be stored properly is of the utmost importance to prevent these medications from being used by someone they are not prescribed to. Hospice personnel will not always be present in the patient’s home to monitor how medications will be handled or who may be present in the home at any given time that could gain access to them; therefore, the patient’s family or caregiver must take on the primary responsibility for ensuring the safekeeping of all controlled substances present in the patient’s home.

Adopt subdivision (s). Subdivision (s) is necessary to establish the requirement that the hospice enter the patient’s wound notes and documentation of wound care in the medical record. This requirement is necessary to establish continuous clinical monitoring and support appropriate care adjustments. This requirement is necessary because caring for patient wounds is an essential skilled nursing service that should be appropriately documented in a patient’s medical record. Hospice patients are often incapable of caring for themselves, therefore it is the responsibility of the assigned nursing staff to provide such care to the patient. Documenting wound notes (or nursing notes) is an effective tool for all nursing personnel to be able to communicate with one another, track how the wound is healing, and make any necessary adjustments. This regulation is necessary to promote communication among the patient’s assigned hospice personnel and ultimately protect the health and safety of the patient.

Adopt subdivision (t). Subdivision (t) is necessary to establish the requirement that the hospice enter the patient’s vital sign tracking information in the medical record. This requirement is necessary to establish continuous clinical monitoring and support appropriate care adjustments, and for the same reasons under subdivision (s). Tracking and documenting a patient’s vital signs are a standard skilled nursing service, and an effective way for nursing and other hospice personnel to monitor a terminally ill patient’s condition. In the event a patient’s vital signs show signs of distress or unexpected decline in health, these notes will allow personnel to track the patient’s progress to adjust the patient’s care, if necessary. This regulation is necessary to promote

communication among the patient's assigned hospice personnel and ultimately protect the health and safety of the patient.

Adopt subdivision (u). Subdivision (u) is necessary to establish the requirement that the hospice enter the patient's documentation of supervisory visits in the medical record. This requirement is necessary to establish supervision of aide and nursing services. This requirement is necessary to establish industry standards. Under Title 42 CFR 418.76(h)(1)(i), the patient's assigned RN must make supervisory visits at least every 14 days to assess the quality of care being provided to the patient by home health aides, LVNs, or other nursing personnel. This regulation is necessary to ensure all RN supervisory visits are properly documented in the patient's medical record.

Adopt subdivision (v). Subdivision (v) is necessary to establish the requirement that the hospice enter the patient's requests to examine, obtain, and request corrections in the medical record. This requirement is necessary to establish transparency and surveyable compliance. This requirement is necessary to ensure all record requests received by the patient or the patient's representative are properly documented as part of the patient's medical record. This is necessary for Department surveyors to confirm that all requests received have been acknowledged and responded to as required under section 74888 (Medical Record Service) subdivision (f)(3).

Adopt subdivisions (w), (w)(1) and (w)(1)(A) through (w)(1)(C). Subdivisions (w), (w)(1)(A)–(H), and (w)(2)(A)–(F) require a detailed discharge statement and specified transfer documentation, including Medical Director concurrence consistent with Title 42 CFR section 418.26(b). These requirements are necessary to establish complete end-of-service records and ensure continuity when a patient transfers. This requirement is necessary to maintain industry standard practices as seen under the CHAPCA Standards. Requiring a detailed discharge statement is needed to maintain a complete medical record that accurately reflects the patient's entire hospice experience. This information is also necessary to have in the event of a complaint.

Adopt subdivision (w)(1)(D) to align with federal CoPs under Title 42 CFR 418.26(b). Such documentation is necessary to ensure that the hospice Medical Director is aware of and in agreement with the patient's discharge. This is intended to protect the health and safety of patients by promoting accountability and meaningful enforcement.

Adopt subdivisions (w)(1)(E) through (w)(1)(G) for the same reasons identified in subdivisions (w), (w)(1) and (w)(1)(A) through (w)(1)(C).

Adopt subdivision (w)(1)(H). This proposed regulation is in alignment with the CHAPCA Standards and necessary to ensure the receiving hospice has all available information about the patient's condition and hospice experience. This will help them determine the most appropriate next steps and provide the best quality care to the patient without any disruptions.

Adopt subdivisions (w)(2), and (w)(2)(A) through (w)(2)(F) which is common industry practice and aligns with the CHAPCA Standards. This basic information is necessary to maintain a complete and accurate medical record of the patient's hospice experience from beginning to end.

Adopt section 74896 “Medical Record Use and Access.”

Section 74896 establishes standards for the use, maintenance, storage, retention, and access of hospice medical records, aligning with Title 42 CFR section 418.104 and CHAPCA standards. This requirement is necessary to establish confidentiality protections, record integrity, 24/7 availability for patient care, and surveyable processes for Department oversight.

Adopt subdivision (a). Subdivision (a) requires each hospice to operate a centralized medical record service for all patient records. This requirement is necessary to establish reliable access to confidential medical histories and support consistent, high-quality care.

Adopt subdivision (b). Subdivision (b) establishes a 10-year retention requirement for adult patient records. For minors, records must be retained until the patient reaches age 19 or for a minimum of 10 years, whichever is longer. This requirement is necessary to establish record integrity and compliance with California law. This regulation was written to align with the medical record retention requirements in California's state Medicaid program, Medi-Cal. Due to the passage of Assembly Bill 1688 (Committee on Health, Chapter 511, Statutes of 2017), the Welfare and Institutions Code (WIC) section 14124.1 was amended to state Medi-Cal providers must store their patients' medical records for a minimum of 10 years. This regulation is necessary to protect the integrity of patient health information and to comply with statutory requirements under California law.

The Department did consider other sources for establishing a retention period requirement. The two primary sources considered were Title 42 CFR section 418.104(d) which requires a retention period of six years, and Section 6.3(B)(3)(b) of the CHAPCA Standards which requires a retention of seven years. The Department, however, determined 10 years to be the appropriate retention period requirement. 10 years was recommended by Department medical record subject matter experts, and additionally while Title 42 CFR section 418.104(d) implements a six-year retention period it also goes on to say “unless State law stipulates a longer period of time” which WIC section 14124.1 does.

Adopt subdivision (c). Subdivision (c) requires patient medical records to be securely stored at the hospice's primary place of business or at a Department-approved offsite location under subdivision (p). This requirement is necessary to establish secure storage and emergency accessibility. This requirement maintains the industry standard known to protect the security and privacy of patient health information. The Department is intentionally leaving it to the discretion of each hospice on how the medical records must be stored and only focusing on the requirement that they must be securely stored

at the hospice agency's established place of business or an approved alternate location that meets the requirements of subdivision (p). This regulation is necessary to ensure patient medical records are safely stored in a location known/approved by the Department, and that they are easily accessible in emergency situations.

Adopt subdivision (d). Subdivision (d) requires uniform medical record maintenance with entries that are legible, authentic, complete, respectful of patient privacy, secure against unauthorized access or disasters, and organized chronologically. This requirement is necessary to establish clear communication among personnel and safeguard record integrity. This requirement is necessary to ensure all patient medical records are properly and uniformly maintained. This is necessary for the patient's health care team to be able to easily review and understand the recorded entries to provide the best quality care.

Adopt subdivision (d)(1) to ensure recorded entries can be easily understood by all hospice personnel and Department surveyors accessing and reading a patient's medical record. If critical information regarding the patient's diagnosis or overall health is written into the record in an illegible manner, that could potentially cause harm to the patient because the critical information cannot be properly communicated to other personnel caring for the patient. This is necessary to promote clear communication among all hospice personnel and prevent any situations that may cause patient harm.

Adopt subdivision (d)(2) for continued uniformity and to ensure the authenticity of patient medical records. Patient medical records contain sensitive and valuable information that must always be handled with integrity and professionalism, and this requirement is necessary to ensure they are standardized, easily recognizable, and authentic.

Adopt subdivision (d)(3) which is necessary for hospice physicians, registered nurses, and other members of the interdisciplinary team to be able to have enough information to be able to make sound clinical decisions for how best to care for the patient.

Adopt subdivision (d)(4) which is necessary to protect the dignity of a dying hospice patient's privacy and the integrity of the medical record system.

Adopt subdivision (d)(5). This regulation is critical for ensuring hospices protect medical record information from access by unauthorized individuals via events such as a medical information breach and ensuring confidential health information remains safe and secure in the event of natural disasters such as fires or earthquakes. This is necessary to align with current standards of practice known to protect patient health information.

Adopt subdivision (d)(6) to ensure a patient's medical record clearly and accurately portrays a patient's medical history. Knowing the sequence of services and events experienced by the patient keeps the record consistently organized, which may be critical for hospice personnel to be able to make sound clinical decisions.

Adopt subdivision (e). Subdivision (e) requires written policies and procedures addressing: (1) medical record content per section 74892; (2) technical recording requirements; (3) maintenance, security, and storage; (4) retention under subdivision (b); (5) authorization levels for entries; (6) user identification standards; (7)(A)–(D) personnel accountability measures; and (8) breach reporting. These requirements are necessary to establish standardized and surveyable documentation. Policies and procedures are an essential way to ensure hospice agencies have a system in place regarding the maintenance, storage, use, etc. of medical records. This is also necessary for proper enforcement, and for the reasons explained previously in “language common to all sections.”

Adopt subdivision (e)(1) to fully establish content of medical record requirements in accordance with section 74892 (Medical Record Content).

Adopt subdivision (e)(2) to establish clear guidelines regarding technical medical record recording requirements.

Adopt subdivision (e)(3) to fully effectuate the maintenance, security, and storage requirements of this article.

Adopt subdivision (e)(4) to fully effectuate the 10-year record retention requirement under subdivision (b).

Adopt subdivisions (e)(5) and (e)(6). Health facilities today typically assign security levels to their personnel to establish who owns, uses, and maintains patient information in medical records. These procedures will help personnel determine who has authority to document information in patient medical records and help ensure entries made by authorized personnel can be easily identified. While it is likely common industry practice for authorized hospice personnel to use a unique identification when documenting in a patient medical record, there is no universal requirement. Every hospice agency will therefore need to develop its own policies, procedures and standards for how its specific personnel must identify themselves when making entries.

These regulations are necessary to protect the health and safety of patients by ensuring the appropriate hospice personnel can be identified and contacted if there is a question or concern regarding any entry in a patient’s medical record. Documented policies and procedures are also necessary so Department surveyors can review them and verify compliance. Furthermore, this regulation is necessary to align with Title 42 CFR section 418.104(b), which requires authentication of all medical record entries.

Adopt subdivisions (e)(7), and (e)(7)(A) through (e)(7)(D) to ensure hospice personnel are easily identifiable and accountable for the accuracy of their medical record documentation. These regulations are necessary to further align with the requirements under Title 42 CFR section 418.104(b), and to help promote accurate medical record documentation for the health and safety of every patient.

Adopt subdivision (e)(8) upon recommendation from internal medical record SMEs because there currently is not a universal standard in place for how to report a discovered or suspected breach. This regulation is necessary to reflect current standards of practice designed to protect patients' personal health information pursuant to the "Breach Reporting Requirements" under Title 22 CCR section 79902.

Adopt subdivision (f). Subdivision (f) requires all authorized individuals to authenticate their identities upon making entries to the record, including the specified information. This requirement is necessary to establish record integrity, enable effective team communication, promote accountability, and support meaningful enforcement. This requirement is necessary to further effectuate and clarify the necessity of subdivision (e)(6). It is necessary for each recording to clearly identify who made the entry to protect the integrity of the medical record system. This information is also necessary to have available to promote effective communication among the patient's care team, for Department surveyors to accurately enforce the requirements of this chapter, and in the event a complaint is received. The requirement for the authorized individual's identity to be disclosed upon entry permits those individuals to be held accountable in the event an error, complaint investigation, or an indication of fraudulent activity arises.

Adopt subdivisions (g) and (g)(1) through (g)(5). Subdivision (g) requires hospice personnel to correct or alter entries using documented methods that capture what was changed, when, why, and by whom. This requirement is necessary to preserve the authenticity of the record and protect patient safety. This requirement is necessary to establish the proper methods that hospice agency personnel must take any time a medical record entry is corrected or altered. This is necessary to preserve the integrity and authenticity of the medical record system by capturing specific and detailed information to prove when the correction occurred, the reason, and by whom. This regulation is necessary to ensure errors to a patient's medical record are not simply covered up but properly recorded and documented. It is critical to properly correct a medical record entry because an uncorrected error could result in improper/low quality care, harm, or even death to a patient. This regulation is necessary to protect patient health and safety by ensuring all hospice personnel properly correct any error made in a patient's medical record or make a note in the patient's medical record when they discover information missing in the patient's medical record.

Adopt subdivision (h). Subdivision (h) requires authorized personnel to correct identified medical record errors within 48 hours. This requirement is necessary to establish timely remediation and prevent patient harm. While state and federal statute or regulations do not specify a specific timeframe for recording medical errors, the Department received recommendations from its consultants that 48 hours is ample time for any authorized hospice personnel to make needed corrections to the record. A timeframe longer than 48 hours could result in patient harm. Establishing the required timeframe for the identified action to be completed is also necessary for proper enforcement by Department surveyors.

Adopt subdivision (i). Subdivision (i) requires addenda to include the date and authentication of authorized hospice personnel and to be stored within the medical record system. This requirement is necessary to establish accountability and prevent harm due to missing information. Requiring addenda to include the date and authentication of the authorized hospice personnel ensures practitioners are accountable for correcting documentation errors in a patient's medical record, and ensures addenda are located in the hospice's medical record system. Addenda are a common industry practice known to help protect patients from harm due to missing information in their medical records. This subdivision is necessary to account for current industry standards of practice and protect patient health and safety.

Adopt subdivision (j). Subdivision (j) requires immediate notation and correction when information for one patient is entered into another patient's record. This requirement is necessary to establish accuracy, prevent improper care, and avoid legal or billing issues. If hospice personnel do not note such mismatch errors immediately, patients could be at risk of receiving improper care. Incorrect information in a patient's medical record can also lead to legal or billing issues. The proposed amendment is necessary to make the regulations consistent with current standards of practice and to protect patient health by ensuring patient medical records contain accurate information.

Adopt subdivision (k). Subdivision (k) requires protection against unauthorized access and measures to safeguard medical records during disasters. This requirement is necessary to establish security and continuity of patient information. This requirement is necessary to prevent access by unauthorized individuals via events such as a medical information breach and ensure private health information remains safe and secure in the event of natural disasters such as floods, fires or earthquakes. This regulation is necessary to protect patient health information.

Adopt subdivision (l). Subdivision (l) requires confidentiality of medical records and clarifies that disclosure may be required under court orders or other lawful circumstances consistent with California law. This requirement is necessary to establish compliance with confidentiality standards because patient medical records contain highly confidential information that must not be shared with any unauthorized person. This requirement is common industry practice that aligns with Title 42 CFR 418.104(c) and Section 6.3(B)(3) of the CHAPCA Standards. This regulation is necessary to clarify that court orders and other legal circumstances allowed and approved under California law may require the hospice agency to release certain patient medical record information.

Adopt subdivision (m). Subdivision (m) requires complete authentication of patient medical records within 30 calendar days. This requirement is necessary to establish timely completion consistent with industry standard practice that align with Section 6.3(B)(3)(b) of the CHAPCA Standards.⁵⁰ Department medical record subject matter

⁵⁰ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 20, Last Accessed on October 28, 2024,

experts have expressed that a 14 calendar day requirement is a sufficient amount of time for other health care facility types such as general acute care hospitals; therefore, 30 days should be more than enough time for hospice agencies to collect signatures from physicians (and/or other health care providers) and fully authenticate a patient's medical record. This regulation is necessary to remain consistent with current standards of practice.

Adopt subdivision (n). Subdivision (n) requires the hospice's medical record service to ensure safe preservation of records if the hospice becomes inoperable and to notify the Department within 24 hours of the storage location. This requirement is necessary to establish continuity of preservation and enforceability of retention under subdivision (b). As the custodians of all patient medical records, a hospice's medical records service must always ensure the safe storage and preservation of patient records, even if the hospice becomes inoperable for any reason; Additionally, the medical record service must still adhere to the record retention requirements of subdivision (b) even if the hospice is inoperable. Methods to safely preserve medical records include engaging a third-party company compliant with the HIPAA to store the hospital's medical records off-site in a dedicated facility or using a HIPAA-compliant cloud server for electronic health records (EHRs). The Department requires immediate notification of where patient medical records will be stored to always ensure their safety. "Immediate notification," however, is vague and unenforceable, therefore within 24 hours was implemented as the new standard to provide clarity to the regulated community. The Department chose to create the 24-hour requirement because it gives facilities sufficient time to relocate their records, if necessary, while also being a short enough time frame to ensure the Department can review medical records and ensure their safety when necessary. This regulation is necessary to align with current standards of practice as seen under Section 6.3(B)(3)(d) of the CHAPCA Standards and ensure the safe preservation of confidential patient information pursuant to the requirements of this Article.⁵¹

Adopt subdivision (o). Subdivision (o) establishes protocols to handle and preserve medical records during a change of ownership under section 74824, with a written declaration by both parties. This requirement is necessary to establish accountability and protect patient information during transitions. This requirement is necessary to establish clear guidelines for how hospice agencies must handle and preserve patient medical records during a change of ownership as outlined in detail under section 74824 (Change of Ownership). The written and signed declaration is necessary to ensure both parties are aware of the outlined protocols and can be kept accountable by Department surveyors.

Adopt subdivisions (o)(1) and (o)(2) to ensure the new licensee does not gain access to patient medical records until they are properly vetted and deemed qualified to accept

https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

⁵¹ California Hospice and Palliative Care Association, "*Standards of Quality Hospice Care, 2005*," Page 21, Last Accessed on October 28, 2024, https://www.calhospice.org/assets/docs/Standards_of_Quality.pdf.

ownership of the hospice. This is necessary to protect the confidentiality of patient medical information.

Adopt subdivision (o)(3) to protect the security of patient health information during any transition of ownership, and to ensure the Department always has access to critical patient information.

Adopt subdivision (p). Subdivision (p) requires a written request to the Department to store records offsite that includes: (1) the offsite location; (2) the number of records and the period to be stored; (3) retention timelines consistent with subdivision (b); (4) policies and procedures for storage and retention; (5) a fully executed contract that affirms Department access; and (6) a HIPAA-compliant Business Associate Agreement, as applicable, that affirms Department access. This requirement is necessary to establish traceability and enforceability of offsite storage.

Adopt subdivision (p)(1) clarifying and confirming the proposed new location for review and approval by the Department.

Adopt subdivisions (p)(2) and (p)(3) confirming the number of proposed records to be stored off-site, and for how long, for proper tracking and enforcement. Department surveyors will need this information for verification/comparison as to whether all records have been safely and appropriately stored according to the requirements of this Chapter. Department surveyors will also need to be able to confirm all records stored off-site are meeting the retention requirements of subdivision (b).

Adopt subdivision (p)(4). Policies and procedures are an essential way to ensure hospice agencies have a system in place regarding the maintenance, storage, use, etc. of medical records. This is also necessary for proper enforcement, and for the reasons described in “language common to all sections.”

Adopt subdivision (p)(5) for proof of agreement and understanding between both parties. This documentation will also be necessary and crucial for Department surveyors to be able to hold both parties accountable in the event the agreement is not followed.

Adopt subdivision (p)(6) for the same reasons described in subdivision (p)(5). The Department must also be able to verify that the contract contains the provision that representatives of the Department will have access.

Adopt subdivision (q). Subdivision (q) requires the hospice to request Department re-approval if the off-site location changes, policies/procedures are amended, or the contract is modified. This requirement is necessary to establish continuous oversight of off-site storage arrangements.

Adopt subdivision (q)(1) to receive confirmation that the new proposed location is acceptable.

Adopt subdivision (q)(2) to ensure the Department has the opportunity to review any changes or amendments to the previously approved policies and procedures under subdivision (p)(4). This will allow the Department to have the information necessary to approve or deny the hospice's request to relocate patient medical records.

Adopt subdivision (q)(3) to ensure the Department has the opportunity to review any changes or amendments to the previously executed and approved contract under subdivision (p)(6). This will allow the Department to have the information necessary to approve or deny the hospice's request to relocate patient medical records.

Adopt subdivision (r). Subdivision (r) requires secure transport, protection against mishandling and disasters, and 24/7 availability of medical records stored offsite. This requirement is necessary to establish confidentiality, continuity, and access for patient care. This requirement is necessary to establish minimum requirements regarding the handling of patient medical records that are stored off-site once approval is received by the Department to do so.

Adopt subdivision (r)(1) to ensure secure transportation of any and all records, which is necessary to protect patient medical record confidentiality.

Adopt subdivision (r)(2) to ensure patient medical records will be safe from mishandling on behalf of the hospice and/or the off-site storage facility and will remain safe by these parties in the event of natural disasters. Patient medical records contain valuable, confidential, and irreplaceable medical history information that always must be protected.

Adopt subdivision (r)(3) to meet the needs of hospice patients and personnel. Hospice care (especially hospice nursing services) is provided to patients 24 hours a day, 7 days a week because hospice patients are suffering from the last stages of life which can require care or assistance any time of day. Patient medical records must therefore also be available 24/7 as needed to provide the best quality care. This regulation is necessary to align with industry practices known to protect patient health information stored at off-site facilities and meet the needs of hospice patients and personnel.

Adopt section 74900 "Electronic Health Records."

Section 74900 establishes additional requirements for hospice agencies that use electronic health records (EHRs), in addition to the standards in section 74892 (Medical Record Content) and section 74896 (Medical Record Use and Access). This requirement is necessary to establish privacy and security safeguards, record integrity, 24/7 availability for patient care, and surveyable processes for Department oversight. (This applies only to agencies that use EHR systems.)

Adopt subdivision (a). Subdivision (a) requires hospice agencies that use EHR systems to comply with the additional requirements in subdivisions (a)(1) through (a)(6), in addition to sections 74892 and 74896. This requirement is necessary to establish secure, reliable, and surveyable electronic records consistent with Title 42 CFR section

418.104. This requirement is necessary to establish clear guidelines for hospice agencies that use electronic health records (EHRs). This regulation is necessary because it is common industry practice for hospice agencies to digitalize patient medical records, and specific requirements must be in place to ensure those electronic records are properly used and maintained. Federal CoPs under Title 42 CFR section 418.104 state that “the clinical record may be stored electronically,” however Section 6.3(B) of the CHAPCA Standards do not specifically mention or specify electronic records. Furthermore, the Department’s intention for this section is to clarify that although the requirements of Section 74892 (Medical Record Content) and Section 74896 (Medical Record Use and Access) apply to both hard copy and electronic patient records, hospice agencies that use any electronic health records must additionally adhere to the requirements of this section. The requirements of this section only apply to hospice agencies that use EHR systems and do not apply to hospice agencies that only use traditional hard copy medical records. These regulations are necessary for the protection of patient health information that is stored electronically.

Adopt subdivision (a)(1). Subdivision (a)(1) requires hospices to define and document authorized access to patient EHRs. This requirement is necessary to establish confidentiality safeguards and limit disclosures consistent with California law. It is necessary to implement this requirement because patient records contain highly sensitive/confidential patient information that hospice personnel should not be able to share with unauthorized individuals. This regulation aligns with the Confidentiality of Medical Information Act under Civil Code section 56.10, which protects the privacy of an individual’s medical information by limiting disclosures from health care providers, health plans, and contractors.

Adopt subdivision (a)(2). Subdivision (a)(2) requires EHR systems to maintain accurate, detailed audit trails that record user, action, timestamp, and changes. This requirement is necessary to establish traceability for clinical decision making and surveyor review. Creating an audit trail is standard industry practice that is known to protect patient health and is necessary to ensure a patient’s hospice care team has all information available to be able to make sound clinical decisions. This information also helps hospice personnel and/or Department surveyors identify the cause of any medical errors that might have occurred.

Adopt subdivision (a)(3). Subdivision (a)(3) requires EHR data to be backed up at least every 24 hours. This requirement is necessary to establish continuity of records during outages and protect patient safety, consistent with applicable security standards. Backing up data every day is a necessary measure to ensure important information does not get lost if an unexpected event occurs overnight. Due to the advancement of current information technology, backing up data no less than every 24 hours is easy to accomplish, and should not be overly burdensome to the hospice agency. If hospice agencies do not backup their EHR systems no less than every 24 hours, then physicians and the patient’s care team are at risk of being unable to access accurate/necessary medical record information. This could further lead to improper care which can cause medical errors or harm. This adoption is consistent with the HIPAA

Security Rule (Title 45 CFR section 164.308(a)(7)(ii)(A)) which specifies facilities must have a data backup plan to align with current standards of practice, and necessary to protect patient health and safety.

Adopt subdivisions (a)(4), (a)(4)(A) and (a)(4)(B). Subdivision (a)(4) requires authentication controls for EHR access and documentation, including electronic signature keys, to identify authorized hospice personnel. This requirement is necessary to establish accountability and protect record integrity consistent with applicable law. Hospice agencies that use EHR systems generally have an authentication system in place so unauthorized individuals cannot gain access to or alter patient EHRs. This requirement is consistent with HSC section 123149(g), which specifies that those who use EHR systems must develop and implement policies and procedures for authentication by electronic signature keys. This regulation is also consistent with current standards of practice and is necessary to ensure hospice EHR systems can identify all hospice personnel authorized to document EHRs.

Adopt subdivision (a)(5). Subdivision (a)(5) requires a documented disaster recovery and downtime plan for EHRs. This requirement is necessary to establish continuity of care and reliable documentation during cyber-attacks, disasters, or system failures. This is necessary to align with the HIPAA Security Rule specifying facilities must have a disaster recovery plan under Title 45 CFR section 164.308(a)(7)(ii)(B). EHR systems can become nonfunctional due to unforeseen events such as a cyber-attack, natural disaster, or theft. This adoption is necessary to ensure critical documentation of patient health or medical information can be safely continued in the event the hospice EHR system is down, and necessary to ensure hospice physicians and personnel can preserve continuity of care in the face of unforeseen events.

Adopt subdivision (a)(6). Subdivision (a)(6) requires hospice EHRs to capture and make accessible patient electronic health information from contracted providers when that data is not automatically linked to the hospice's primary EHR system. This requirement is necessary to establish complete patient records and support sound clinical decisions. Hospice agencies that have contract services may come across providers that do not use the same primary EHR system as the hospice, which means there may be times when hospice personnel do not receive the medical information needed to make clinical decisions for patients. For example, a patient may have blood work done through a contracted lab service which does not link the results in the hospice's primary EHR system. This poses a problem for hospice medical professionals trying to determine how to provide the best care for that patient. This requirement is necessary to ensure patients' health and safety by requiring accurate information is properly recorded and available in a patient's EHR so personnel can make sound clinical decisions and provide effective care to patients.

Adopt subdivision (b). Subdivision (b) requires hospices that use cloud-based EHRs to maintain secure remote access and ensure records are always available. This requirement is necessary to establish continuous availability and protect patient information consistent with security and privacy laws. This requirement is necessary to

establish industry standards based upon recommendation from internal medical record SMEs. Hospice agencies routinely store EHRs that were originally on the hospice's software or hardware devices through a third-party company on a cloud-based server. Hospices that store their patient EHRs through a cloud-based server must have remote access to patient EHRs, and the patient information must still be available and accessible at all times. This provision is necessary to reflect current industry practices, ensure hospice agencies follow existing security and privacy laws, and to ensure patients' medical information is protected.

Adopt subdivision (c). Subdivision (c) requires Department approval before a physical EHR server is stored offsite and provides a cross-reference to the request contents in section 74896(p). This requirement is necessary to establish secure storage, clear Department access, and emergency readiness. This requirement is necessary because if a hospice chooses to use a physical server and house it off-site the Department must be able to approve that the proposed storage location is acceptable and be aware of the server's exact location in case of an emergency or disaster. This is particularly important in areas that are prone to natural disasters, such as California which experiences fires and earthquakes. The specific details regarding how to request and obtain approval from the Department can be found in section 74896 (Medical Record Use and Access) under subdivision (p). This regulation is necessary to protect the health information of Californians, which in turn protects their health and safety.

Adopt section 74904 “Plan of Correction.”

Section 74904 establishes requirements for an acceptable Plan of Correction following Department inspections, aligning with State Operations Manual Appendix M and related Title 22 licensing types (e.g., HHA Title 22 CCR section 74744(b)). This requirement is necessary to establish standardized corrective actions, clear timelines, and surveyable documentation to protect patient health and safety. When the Department identifies a deficiency, a Plan of Correction is required.

Section 74904 was written to align with current standards of practice in State Operation Manual “Appendix M - Hospice” and similarly related Title 22 facility types such as HHA regulations under Title 22 CCR section 74744(b).⁵² It is necessary to adopt and clarify to the regulated community what an acceptable Plan of Correction entails to ensure that each identified deficiency can be timely and correctly addressed by the hospice agency to protect the health and safety of patients.

Adopt subdivision (a). Subdivision (a) requires hospice agencies to complete a Statement of Deficiencies and Plan of Correction form State-2567, with a version date of May 2026. The State-2567 is typically electronically generated upon completion of a survey, which includes the specific deficiencies that the agency is non-compliant with. The Department included a link to a sample form for full transparency. After an

⁵² State Operations Manual, “Appendix M – Guidance to Surveyors: Hospice,” Page 72, Last Accessed January 23, 2025, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf.

inspection of a hospice agency, Department surveyors will hold an exit conference where typically the hospice Administrator (or their Designee) will be provided with the result of the inspection. This includes information about the preliminary findings of the inspection and identifying any deficiencies of State laws and regulations, if applicable. The hospice must then return the completed form within 10 days of receipt, which is current industry practice. This requirement is necessary to establish a uniform, timely corrective process. This proposed regulation is also necessary to clearly identify the specific actions/details hospice agencies must meet to complete and submit an acceptable plan of correction. An acceptable completed plan of correction must address the following elements:

Adopt subdivision (a)(1). Subdivision (a)(1) requires the plan of correction to include corrective actions for each cited deficiency, sufficient for Department review and approval. This requirement is necessary to establish actionable, deficiency-specific remedies. The hospice agency must present the Department with a proposed plan for how they intend to address each cited deficiency. The Department must be able to review the proposed plan and confirm it will appropriately solve the identified issue.

Adopt subdivision (a)(2). Subdivision (a)(2) requires procedures and implementation steps for each corrective action. This requirement is necessary to establish executable plans that can be verified by surveyors.

Adopt subdivision (a)(3). Subdivision (a)(3) requires monitoring mechanisms to evaluate the effectiveness of corrective actions and adjustments when deficiencies persist. This requirement is necessary to establish continuous improvement and protect patient health and safety. This requirement is necessary to ensure the hospice agency continually observes the implementation process and confirms that the proposed plans of correction are fully effective in resolving the issues cited by the Department. This is necessary to protect the health and safety of patients by preventing a hospice agency from reporting they will fix a deficiency without having a plan in place for monitoring the effectiveness of the plan. In the event the proposed plan of correction does not fully and continuously resolve the issue, the hospice agency must make necessary adjustments to ensure hospice patients are no longer at risk of the identified deficiencies.

Adopt subdivision (a)(4). Subdivision (a)(4) requires the plan to identify each deficiency by citation and assign responsibility and completion dates. This requirement is necessary to establish accountability and enable surveyor verification.

Adopt subdivision (a)(5). Subdivision (a)(5) requires Administrator signature on the plan of correction. This requirement is necessary to establish executive accountability for corrective actions. This requirement is necessary to ensure that the individual within the hospice that is responsible for the administrative management of the agency is involved in the plan of correction process and has the final opportunity to “sign-off” on the validity/accuracy of the corrections. Limiting the signature to only the hospice Administrator will ultimately help protect the health and safety of patients.

Adopt subdivisions (b) and (b)(1) through (b)(3). Subdivisions (b)(1)–(b)(3) specify when a plan of correction is unacceptable, including (1) failure to address each cited deficiency; (2) insufficient procedures or monitoring; (3) lack of assigned responsibility or Administrator signature. These requirements are necessary to establish thorough, verifiable remedies. The reasons listed are consistent with the requirements under subdivision (a) of this section and are necessary to ensure a hospice’s proposed action plan will thoroughly and properly remedy all cited deficiencies to protect the health and safety of patients.

Adopt subdivision (c). Subdivision (c) authorizes the Department to reject a plan of correction until it meets the requirements of this section. This requirement is necessary to establish enforceable standards and ensure all deficiencies are appropriately remedied. This requirement is necessary to establish that the Department will continually reject a proposed action plan until all cited deficiencies can be appropriately remedied.

Adopt section 74908 “Hospice Office Space.”

Section 74908 establishes office space standards for hospice agencies, as required in HSC section 1753.1(e) to ensure clear public identification, secure operations, and surveyable compliance. This requirement is necessary to establish visible signage, professional communications, secure storage, and readiness measures that support enforcement and protect patient health and safety. The Audit Report noted that many hospice agencies lacked such basic identification, which contributed to the suspicion that there were fraudulent businesses and activity within the industry. The proposed regulations of this section will provide Department surveyors with the tools they need to take enforcement action against such agencies and ultimately protect the health/safety of hospice patients.

Adopt subdivision (a). Subdivision (a) requires each hospice agency to maintain a physical office that meets the definition of an “established place of business” pursuant to section 74800(a)(22) and the standards in this section. This requirement is necessary to establish professional operations, secure handling of sensitive information, and surveyable compliance.

Adopt subdivision (a)(1). Subdivision (a)(1) prohibits use of shared workspaces (e.g., office hubs or coworking environments) for hospice operations. This requirement is necessary to establish dedicated, secure space for confidential patient information and preserve patient privacy and dignity.

Adopt subdivision (a)(2). Subdivision (a)(2) requires use of a commercial office and prohibits operation from a personal residence. The hospice must maintain a consecutive 12-month rental or sublease agreement. This requirement is necessary to establish professional, secure operations and ensure continuity of compliance. Non-commercial spaces, such as a licensee’s personal residence, are not secure nor professional enough to conduct hospice business involving highly sensitive and private medical

information. Requiring a consecutive 12-month rental/sublease agreement is necessary to ensure continued compliance.

Adopt subdivision (b). Subdivision (b) requires the hospice office to include the elements specified in subdivisions (b)(1) through (b)(10). This requirement is necessary to establish public identification, reliable communication, adequate staffing, secure storage, and readiness for patient care.

Adopt subdivision (b)(1). Subdivision (b)(1) requires consistent, permanently attached signage that clearly identifies the hospice agency at the licensed address. This requirement is necessary to establish public identification and deter fraudulent misrepresentation. Requiring consistent and permanently attached signage is a basic business necessity for the public to be able to easily locate the agency. Department surveyors have seen instances where fraudulent actors simply taped handwritten paper as their signage; therefore, this requirement will deter future fraud because those individuals would have to take extra measures and incur additional costs to try to evade scrutiny from Department surveyors to meet the requirements of these sections. This regulation is necessary to help prove the legitimacy of established hospice agencies.

Adopt subdivisions (b)(2) and (b)(3). Subdivisions (b)(2)–(b)(3) require a professional business telephone line (not a personal line) and 24/7 responsiveness to patient and caregiver calls. This requirement is necessary to establish reliable communication for urgent hospice care needs. Additionally, this regulation is necessary to clarify that a hospice agency’s telephone must be answered 24/7 and cannot be a personal line. Hospice patients suffering from a terminal illness require around-the-clock care and may need to contact nursing staff at any time of day for guidance, assistance, and emergencies. To protect the health and safety of patients it is imperative that the agency’s professional line is always managed.

Adopt subdivision (b)(4). Subdivision (b)(4) requires adequate staffing at the hospice office to support daily operations and patient services. This requirement is necessary to establish operational continuity and timely support for patients and personnel. This is necessary for the hospice agency to run and operate smoothly, and to be able to provide high-quality care to all patients.

Adopt subdivision (b)(5). Subdivision (b)(5) requires the hospice office to provide necessary equipment and supplies and to store them securely to ensure availability and readiness. This requirement is necessary to establish safe, effective patient care and support personnel. Patients will need varying services and care throughout their hospice experience, so it is imperative those patients and the personnel caring for them have what is needed to provide the best care and experience. This includes proper and secure storage for all equipment/supplies to ensure availability and readiness.

Adopt subdivision (b)(6). Subdivision (b)(6) requires support services sufficient to maintain operations and assist patients and personnel. This requirement is necessary to establish reliable office functions and care coordination.

Adopt subdivision (b)(7). Subdivision (b)(7) requires secure storage of patient medical records at the established place of business, consistent with section 74896 (Medical Record Use and Access). This requirement is necessary to establish confidentiality, integrity of the medical record system, and ready accessibility for authorized personnel and surveyors. This is necessary to protect the dignity of hospice patient's privacy and the integrity of the medical record system. Additionally, requiring medical records to be securely stored at the hospice agency's established place of business ensures all confidential records are in a location known to and approved by the Department, and that they are readily accessible.

Adopt subdivision (b)(8). Subdivision (b)(8) requires secure storage of medications and controlled substances to prevent unauthorized access or misuse. This requirement is necessary to establish patient and public safety. Medications are carefully prescribed by licensed medical professionals to specific individuals and must always be safely stored. If someone other than the intended party were to misuse, abuse, or improperly take that medication it could cause serious harm such as allergic reactions, organ damage, stroke/coma, or overdose. This regulation is necessary to minimize risks and protect public health and safety.

Adopt subdivision (b)(9). Subdivision (b)(9) requires confidential storage of personnel records and personal identifying information consistent with section 74884 (Personnel Records). This requirement is necessary to establish privacy protections and prevent unauthorized disclosure. This regulation is common practice and necessary to protect the personnel information of hospice employees.

Adopt subdivision (b)(10). Subdivision (b)(10) requires a public restroom for staff, patients, and visitors. This requirement is necessary to establish basic business accommodations and support safe, professional operations. A legitimate business should have a public restroom for staff, potential patients, and the public to use, which is common industry practice.

STATEMENTS OF DETERMINATIONS AND ECONOMIC IMPACT ASSESSMENT

The Department had extensive stakeholder engagements and there was significant consensus on the regulation as proposed. The Department has therefore determined that no reasonable alternative considered by the Department, or that has otherwise been identified and brought to the attention of the Department, would be more effective in carrying out the purpose for which the regulations are proposed, would be as effective and less burdensome to affected businesses and private persons than the proposed regulations, or would be more cost effective to affected businesses and private persons and equally effective in implementing the statutory policy or other provision of law. The proposed regulations include the topics mandated by the Legislature to adopt emergency regulations under HSC section 1753.1 from recommendations found in the California State Auditor Report 2021-123 on the California Hospice Licensure and Oversight (March 29, 2022).

EVALUATION AS TO WHETHER THE PROPOSED REGULATIONS ARE INCONSISTENT OR INCOMPATIBLE WITH EXISTING STATE REGULATIONS

The Department has reviewed existing state and federal regulations and concluded that the proposed regulations are not incompatible with existing state or federal regulations.

MANDATED BY FEDERAL LAW OR REGULATIONS

The Department has determined that this proposal is not mandated by federal law or regulations. These regulations exceed the minimum requirements under federal law.

LOCAL MANDATE

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

FISCAL IMPACT ASSESSMENT

- A. Cost to Any Local Agency or School District: None
- B. Cost or Savings to Any State Agency: The Department has determined that the proposed regulations will affect two state-run hospice facilities. The Department estimates that the initial cost per hospice facility is \$5,098. The total costs of \$10,196 for both state-run hospice facilities are expected to be absorbed within existing budgets and resources.
- C. Other Nondiscretionary Cost or Savings Imposed on Local Agencies: None
- D. Cost or Savings in Federal Funding to the State: None

INCORPORATIONS BY REFERENCE

- “Hospice Request for Certification in the Medicare Program,” CMS-417 (02/26), published by the Centers for Medicaid and Medicare Services
- “Hospice Survey and Deficiencies Report,” CMS-643 (06/08), published by the Centers for Medicaid and Medicare Services
- “Health Insurance Benefit Agreement,” CMS-1561 (07/01), published by the Centers for Medicaid and Medicare Services
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