



December 8, 2025

**MEMO**

**TO:** OFFICE OF ADMINISTRATIVE LAW STAFF

**FR:** JENNIFER MOORE BALLENTINE, CEO

ON BEHALF OF COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

**RE:** COMMENTS ON PROPOSED HOSPICE REGULATION TEXT, DPH-19-002E, 11/19/2025

**Sustaining Supporters**

Alliance of Catholic Health Care

Sutter Health

Cedars-Sinai Medical Center

Sharp HealthCare

Blue Shield of California

Emanate Health

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

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

There are a few matters, however, that we feel require some additional attention and possible modification prior to implementation:

**1. General observation/question regarding compliance by existing hospices.** It is unclear to us at what point, and how, currently licensed hospices will be required to comply with the new regulations. It is also unclear whether currently licensed and operating hospices would be required to comply in every respect to the regulations or whether some deviations from the requirements might be “grandfathered.” In particular, **we recommend that requirements regarding geographic service area, calculation or unmet need for every county currently being served, and prior work experience requirements for key staff should have some flexibility or timeline to allow for full compliance.** Alternatively, hospices that already have approved and established service areas from the State, and that have been caring for their communities since prior to 2000, could have their service areas, and programs, grandfathered as-is.

**2. Limit on number of licenses per owner.** While we recognize that some hospice owners have “branches” that may require multiple licenses, **we would recommend that there be either a maximum number smaller than 10 on the total number of licenses per owner or a limit on the number of licenses that can be obtained in a given timeframe (e.g., 5 years).**

**3. Admission of unrepresented patients and limitation of service to permanent residents of California.** (§74860. Admission, p. 55).

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

Hospices are barred by these regulations from accepting a “patient for service if the patient does not permanently reside in the hospice’s approved geographic service area” (§74860(f), p. 57). This leaves out accepting patients who may have residences in California and another state, who may be “permanently” resident in another state or country but temporarily living with or being cared for by family members in California, or who may become ill while visiting the state. **We would recommend removing this requirement entirely.**

**4. Patient’s representative**

As defined (§74800. Definitions, item (45), p. 7), the patient’s representative is NOT legally authorized to sign a patient’s advance directives at admission (§74860 3.A & 3.B. Admission, p. 57). Only a patient can sign their own advance health care directive, and only a legally authorized surrogate decisionmaker can sign a POLST or out-of-hospital DNR on behalf of an incapacitated patient (see CA Probate Code, Div. 4.7 Health Care Decision, Pt. 2, Uniform Health Care Decisions Act, [Chapter 3 Health Care Surrogates](#)). **This section of the proposed hospice regulations should be edited to read:**

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

(A) A copy of the advance health care directive prepared and signed by the patient or advance medical order such as POLST or out-of-hospital DNR signed by the patient or the patient’s legally authorized decisionmaker.

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

**5. Geographic Service Area** (§74820, Geographic Service Area, p. 25)

The proposed regulations require hospices to limit a geographic service area to within a radius of the ability of hospice personnel (specifically, a nurse) to respond in person to a patient’s need within 2 hours, as measured from the “parent hospice’s address as indicated on the application for hospice licensure” (§74820(c), p. 25). We wish to note that many hospices maintain branch or satellite locations, which may extend the response radius beyond 2 hours from the *parent* location or, in the case of after-hours response, employ nurses whose homes’ locations may extend the response radius. **We recommend that the language be modified to take into account branch locations or after-hours response times.**

**6. Unmet need calculation/demonstration** (§74820, (3)(e), Geographic Service Area, p. 25)

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

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

A caseload ratio of 12:1 (patients to licensed nurse with primary responsibility for the patients within the nurse’s scope of practice) may be optimal, but we feel it is unrealistic given current constraints on the nursing workforce in general and on the pool of nurses trained to care for hospice patients in particular. Hospice census and staffing levels are subject to fluctuation: A sudden spike in census or deficit in staffing or change in the distribution of patients (e.g., in facilities or at home) will all play into daily patient:nurse ratios. **We would recommend raising the ratio to a maximum of 15:1 to allow for such fluctuations while still ensuring high-quality care. We would also recommend that licensed vocational nurses (LVNs) not be considered in this regulation.**

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

The current text of the regulations does not allow hospices to accept a new senior staff members’ credit for any training completed prior to the date of hire. While we support the comprehensiveness of the education requirements in the regulations, **we would recommend that the hospice be allowed to accept equivalent training from accredited training providers that was completed within one year prior to the date of hire. In particular, if a new-hire hospice Medical Director has completed Hospice Medical Director certification within the past 2 years, this should be accepted as equivalent training.**

**8. Qualifications and experience of Hospice Medical Director** (§74856. Medical Director, (f) & (g), p. 53)

The proposed regulations require that the hospice Medical Director “must have a minimum of two years of full-time supervisory or managerial experience in a hospice, home health agency, or providing palliative care to patients within the last five years” (§74856(b)(2), p. 53). Given that there are very few physicians working full time in supervisory/managerial roles in hospice, home health, or palliative care, we believe this is an unrealistic expectation. **We would recommend that instead that medical directors hold a current, unrestricted license to practice medicine in California AND demonstrate a minimum of 400 hours of broad hospice- or palliative-care related experience, OR a minimum of 2 years full-time or part-time supervisory or managerial experience in a hospice, home health agency, or providing palliative care to patients, OR three years full or part-time experience providing direct patient care in hospice, home health, or palliative care within the last five years.**

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

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

The Medical Director “must not have concurrent employment with other hospices” (§74856(f)) but “may be concurrently employed or contracted by no more than three hospices only if all hospices are located in the same rural area” (§74856(g)). We note that in California there are many very small hospices (serving <50 or even <20 patients) operating in urban as well as rural areas. These hospices must (by regulation and by best practice) have a qualified medical director, but they would be hard pressed to afford a full-time contract with any qualified physician. Hospice medical directors may spend as little as 10 hours per month on supervisory/management activities for a small or very small hospice. Limiting medical directors to “employment” with only one hospice outside of a rural area will make it very difficult for these very small hospices to obtain the services of a qualified medical director. **We recommend that the regulations allow medical directors to contract concurrently with a maximum of 3 hospices, whether in rural or urban areas.**

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

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

**9. Additional recommendations.** Currently, hospices are “required” by federal regulation to report quality measures, but may pay a penalty to be exempted. As well, new and very small hospices may apply for exemption. Patients and families, as well as referral sources, cannot make informed choices about hospice care – for which the timeframe of service is typically short and the opportunities to resolve problems or change providers very few – without access to comparative quality indicators. **We strongly urge CDPH to include a requirement that all hospices, in order to obtain or renew their license, be required without exception or exemption to publicly report hospice quality measures per the Center for Medicare and Medicaid Services data collection recommendations/requirements. Finally, we urge CDPH to include a requirement that all licensed hospices demonstrate adherence to the federal Conditions of Participation with respect to volunteer hours and bereavement programs. Specific definition, above a rock-bottom level, of what constitutes a bereavement “program” with respect to staffing, services, and content should be articulated in the regulations.**

Thank you!