

# California Adopts First-Ever Hospice Licensing Regulations

Insights

06.12.26

On June 11, 2026, the California Department of Public Health (“CDPH”) filed emergency regulations establishing the first comprehensive licensing framework for hospice agencies in California (“Proposed Regulations”). The Proposed Regulations, codified at Title 22, California Code of Regulations, sections 74800 through 74908, implement Health and Safety Code § 1753.1, which directed CDPH to adopt emergency regulations addressing hospice fraud indicators identified in the 2022 California State Auditor Report (Report 2021-123). *The Proposed Regulations are set to take effect on June 22, 2026. CDPH is accepting public comments during a five-calendar-day window from June 11 through June 16, 2026.*

The Proposed Regulations are extensive, covering licensing, patient care standards, staffing ratios, geographic service areas, change of ownership, management qualifications, training, medical records, and enforcement. They arrive at a challenging time for California hospice providers. At the federal level, the Provisional Period of Enhanced Oversight (“PPEO”) pre-payment claims review program has resulted in revocation for over 20% of hospices subject to PPEO review, CMS has [imposed a first-ever nationwide six-month enrollment moratorium](#) on new hospice and home health agency Medicare enrollment, and [affiliation-based revocations](#) continue to create cascading consequences for providers across California. Hospice operators must carefully navigate this complex dual-track system of state and federal regulation.

## Background

In March 2022, the California State Auditor published Report 2021-123, finding widespread indicators of fraud and abuse in California’s hospice industry, particularly in Los Angeles County. The Report documented alarming practices: one administrator managing 27 hospice agencies, multiple agencies sharing the same business address or operating without signage, agencies obtaining licenses and immediately advertised for sale as “brand new, never billed,” management personnel with no hospice experience, and geographic service areas too large for agencies to provide timely care.

The Legislature responded with a series of measures. [SB 664 \(2021\)](#) imposed a moratorium on new hospice licenses. [AB 2673 \(2022\)](#) directed CDPH to adopt emergency regulations addressing the Auditor’s recommendations and granted CDPH express authority to do so under Health and Safety Code § 1753.1. [AB 177 \(2024\)](#) extended the regulatory deadline to January 1, 2026, and set the moratorium to expire on January 1, 2027, or one year after the emergency regulations are adopted, whichever is sooner.

## PROFESSIONAL



**MICHAEL SHIMADA**  
Associate  
San Francisco



**DAVID J. VERNON**  
Partner  
Washington, D.C.



**MATTHEW CLARK**  
Partner  
San Francisco



**JORDAN KEARNEY**  
Partner  
San Francisco



**NINA ADATIA MARSDEN**  
Partner  
Los Angeles

Until now, the only existing California standards governing hospice agencies were the California Hospice Licensure Act of 1990 (Health and Safety Code Division 2, Chapter 8.5) and the California Hospice and Palliative Care Association (“CHAPCA”) Standards for Quality Hospice Care of 2003, incorporated by reference in Health and Safety Code § 1749(e). California hospices have been operating in a regulatory vacuum.

### **Geographic Service Area and “Unmet Need” Requirements**

The Auditor Report found that some hospices were licensed to serve over 30 counties spanning more than 100 miles, raising concerns about response times and quality of care. The Proposed Regulations address this through two requirements: (1) a two-hour travel time limit and (2) a county-level “unmet need” formula.

Under proposed § 74820, a hospice must guarantee that a licensed nurse can appear in person within two hours of receiving information that a patient has a medical need or safety concern. The geographic service area is calculated based on four distance samples taken during peak traffic hours (7:00 to 9:00 a.m. or 4:00 to 6:00 p.m. on a non-holiday weekday) from the parent agency’s address.

As part of the licensure application, each county in a hospice’s proposed service area must also demonstrate “unmet need” for hospice services using a formula specified in the regulations. An applicant applying for a change of ownership after the five-year change of ownership moratorium is exempt from demonstrating unmet need if both of the following conditions are met: (1) The current licensee previously demonstrated to CDPH that there is an unmet need for hospice services in the hospice’s geographic service area; and (2) The hospice’s geographic service area will not change upon the change of ownership.

The formula uses cancer death data from the California Health and Human Services Agency Open Data Portal, applies a 0.7 multiplier to account for non-cancer terminal illness patients, applies a 0.5 multiplier for utilization rates, and compares the resulting figure against the assumed capacity of existing licensed hospices in the county. That assumed capacity is calculated by multiplying the number of licensed hospices by 56 (the statewide average number of patients per hospice outside of Los Angeles County, as reported by the Auditor). If the number of individuals likely eligible for hospice care exceeds the assumed capacity of existing hospices, the county qualifies. Counties that do not demonstrate unmet need cannot be included in a hospice’s approved geographic service area.

The formula is designed to prevent oversaturation and clustering of hospice agencies, which is consistent with the anti-fraud objectives of the legislation. But legitimate operators seeking to enter markets with underperforming incumbents may find it difficult to demonstrate unmet need even where the quality of existing services is inadequate. In essence, the unmet need formula simply counts licensed hospices. It does not consider the quality or adequacy of the services the existing hospices provide.

### **12:1 Nurse-to-Patient Ratio**

Proposed § 74848 establishes a 12:1 nurse-to-patient ratio: a licensed nurse (registered nurse or licensed vocational nurse) may be assigned no more than 12 patients at any one time. This is a first-of-its-kind requirement in the hospice industry. CDPH arrived at 12:1 based on data from the National Hospice and Palliative Care Organization showing a historical median caseload of approximately 12 patients per registered nurse case manager, a 2022 BerryDunn study reporting an average caseload of 13 to 18 patients, and extensive stakeholder input. CDPH initially discussed a 15:1 ratio with industry stakeholders, but labor organizations advocated for a lower ratio, and CDPH ultimately adopted 12:1.

The regulations also require hospices to provide 24/7 licensed nursing staffing and to implement a patient acuity system to determine appropriate caseloads. The patient acuity system must be reviewed at least annually by a committee appointed by the Director of Patient Care Services, at least half of whose members must be registered nurses who provide direct patient care. If the committee determines that adjustments are necessary, they must be implemented within 30 days. Only nurses employed by or contracted with the hospice and assigned to provide direct patient care count toward the ratio.

The ratio allows for both RNs and LVNs, which is more flexible than a pure RN ratio, but it still represents a significant new compliance obligation, particularly for agencies that have historically operated with higher caseloads. The patient acuity system adds an additional layer of administrative requirements, including annual committee review, documentation of all meetings and adjustments, and a process for interested personnel to provide input on the system.

### **Management Personnel Requirements**

The regulations establish detailed requirements for the three key management positions (the Administrator, the Director of Patient Care Services (“DPCS”), and the Medical Director) as well as designated alternates (so-called “designees”) for each position. All management personnel must be appointed in writing by the hospice’s governing body.

### **Concurrent Employment Limits**

Administrators and DPCS may manage only one hospice agency, with an exception allowing concurrent employment at up to two hospices if both are located in the same rural area (defined as a county with a population under 150,000). Medical Directors may manage only one hospice, with a rural area exception allowing up to three. These limits directly target the Auditor’s finding that management personnel were overseeing more agencies than they could realistically manage.

For investors and acquirers, these limits have direct implications for multi-site hospice platforms and roll-up strategies. A single Administrator or Medical Director cannot oversee a portfolio of hospices across non-rural California counties. Each non-rural hospice will require its own dedicated management team.

### **Qualification Requirements**

The regulations set minimum education and experience standards for each management position:

- DPCS: Must be a registered nurse with either (1) a baccalaureate or higher degree in nursing or a health-related field and a minimum of two years of full-time supervisory or managerial experience in a hospice or home health agency within the last five years, or (2) a minimum of four years of full-time supervisory or managerial experience in a hospice or home health agency within the last five years.
- Medical Director: Must hold a current California physician and surgeon license and have a minimum of two years of full-time supervisory or managerial experience in a hospice, home health agency, or providing palliative care within the last five years.
- Administrator: Must have a baccalaureate degree or higher in a health-related field and a minimum of two years of full-time supervisory or managerial experience in a hospice, home health agency, primary care clinic, or health facility within the last five years.

These requirements are more restrictive than the existing CHAPCA Standards in several respects. CHAPCA required only one year of supervisory experience out of three to four total years; the new regulations require all qualifying years to be full-time supervisory or managerial experience. CHAPCA accepted qualifying experience from primary care clinics and health facilities for the DPCS position; the new regulations narrow qualifying settings to hospice and home health agencies only. CHAPCA did not specify a minimum number of years for Medical Directors or require a baccalaureate degree for Administrators; the new regulations impose both requirements. CDPH justifies these restrictions under Health and Safety Code § 1753.1(d)’s mandate for “hospice specific” training and experience standards, though the narrower candidate pool may present hiring challenges, particularly in rural and underserved areas.

### **Other Management Requirements**

The Administrator or Administrator Designee must be on the premises of the hospice or accessible by telecommunication during their scheduled work hours. Each management position must have a written designee who meets the same qualifications and can assume the role when the primary is unavailable. Individuals with disciplinary actions against their professional license within the past seven years are ineligible to serve as management personnel. Vacancies must be filled

within 60 days, with extensions available upon a documented showing of recruitment efforts and an attestation that the vacancy will not diminish the quality of patient care.

### **Change of Ownership and Ownership Reporting**

The Proposed Regulations revise the existing hospice change of ownership (“CHOW”) framework in several important ways.

#### **Five-Year CHOW Moratorium Reset**

Health and Safety Code § 1748(e) prohibits a change of ownership within five years of initial licensure, with limited exceptions for emergency conditions, financial hardship, limited resources, death of the licensee, or receivership. The Proposed Regulations clarify that the five-year clock resets with each approved CHOW. Applicants can apply for a CHOW during the five-year moratorium only if they can demonstrate to CDPH that the CHOW is necessary to ensure continuity of care for patients when the applicant is encountering (i) emergency conditions, (ii) limited resources and capacity, or (iii) financial hardship. This means a hospice acquired through a CHOW cannot be resold for another five years absent the narrow statutory exceptions. While the moratorium itself is statutory, the reset provision is a new and significant regulatory addition that could hinder acquisition activity.

#### **Reclassification of Equity Transactions**

One of the most significant practical changes in the regulations is the reclassification of equity transactions. Under the current regulatory framework, a stock transfer that results in a new person or entity holding a majority of a hospice's equity interests is reported to CDPH within 10 days *after* closing as a “change of stock transfer,” and transfers below 50% were reported post-closing as a change of information. The Proposed Regulations take a different approach:

- A transfer of beneficial ownership interest resulting in the receiving entity holding 50% or more of the hospice's ownership interest constitutes a full CHOW under proposed § 74824(a)(1), requiring a more fulsome 120-day advance application and CDPH approval before the transaction can close.
- A transfer of beneficial ownership interest of 5% or more but less than 50% requires a slimmed down 120-day advance application and CDPH approval under § 74828(a)(1)(B).

This is an inversion of the prior timing and approval framework. Equity transactions that were previously reported post-closing now require pre-closing regulatory approval with a 120-day lead time. This new approach is similar to how CDPH already treats home health agency ownership changes, but the 120-day advance requirement goes further than the home health agency framework. Hospice operators and investors will need to build these timelines into deal planning and should expect that CDPH's review process will become a gating item for transactions.

#### **Other Reporting Requirements**

Other reporting requirements include:

- Changes to indirect ownership, geographic service area, and beneficial ownership transfers of 5% or more: 120-day advance applications;
- Changes to location, services, or suspension of optional services: 60-day advance applications; and
- Changes to management personnel, governing body, Medicare/Medi-Cal certification status, hospice name, mailing address, or property owner: reporting within 10 business days.

Providers should remember that the state-level CHOW framework operates alongside the new CMS Medicare enrollment moratorium. Even if a CHOW is approved at the state level, the federal moratorium may separately restrict Medicare enrollment changes. Providers should evaluate both state and federal requirements when planning transactions.

#### **Terminal Illness Certification: 12 Months vs. 6 Months**

Under Health and Safety Code § 1746(p), a “terminal illness” is a life expectancy of 12 months or less. This differs from the federal Medicare standard under 42 C.F.R. § 418.3, which uses a 6-month prognosis. The Proposed Regulations require the Medical Director to certify terminal illness using the state definition and to include an individualized narrative (not checkboxes or boilerplate language) explaining the clinical findings supporting the 12-month prognosis. The certification must be signed by both the Medical Director (or designee) and the patient’s attending physician (or a covering hospice physician).

The Finding of Emergency accompanying the regulations explicitly acknowledges this divergence and states that CDPH “must adhere to and enforce” the state definition. Dual-certified hospices will need to navigate both standards: a patient may qualify for state-licensed hospice services under the 12-month prognosis but not for Medicare reimbursement under the 6-month standard.

### **Application Requirements and Denial Grounds**

The Proposed Regulations include what are among the most detailed licensing application requirements in Title 22. Proposed § 74812’s licensing application requirements are substantially more prescriptive than the current hospice application process, which relies on the standard HS 200 form series used across CDPH-licensed facility types. Required content includes 10-year employment and adverse action history for all individuals with 5% or more ownership interest or control interest, photo identification, Social Security numbers, professional licenses, OIG exclusion list clearance, proof of financial capacity for a minimum of 90 days, and detailed geographic service area calculations with supporting documentation.

The denial grounds are similarly detailed. An application will be denied if management personnel have disciplinary actions against their professional license within the past seven years and the applicant fails to replace the individual after being notified by CDPH. Other denial grounds include failure to demonstrate unmet need, failure to submit a complete application, unpaid licensing fees, inactive Secretary of State or Franchise Tax Board status, and providing inaccurate information. Licenses may be suspended or revoked for failure to comply with regulations, failure to implement plans of correction, unreported changes, unpaid fees, or operating with an expired license. Licensees have 15 days to request a hearing to contest a revocation or suspension.

### **Office Space and Training Requirements**

The Proposed Regulations require each hospice to maintain an established place of business consisting of unshared commercial office space where the licensee has exclusive possession, located in a commercial building owned or leased by the licensee for a minimum of 12 consecutive months. The office must include permanently attached exterior and interior signage identifying the hospice, an active business telephone line answered 24 hours a day, seven days a week, and secure storage for patient medical records, medications, and personnel records. These requirements are directly targeted at the Auditor’s finding that fraudulent agencies shared addresses, operated without signage, and lacked the basic infrastructure of a functioning hospice. These requirements are relatively straightforward, but the exclusive-possession requirement may affect hospices operating in shared medical office buildings.

The Proposed Regulations also establish management training requirements developed with significant stakeholder input. First-time management personnel (individuals who have never served in that role at a California hospice) must complete 24 hours of educational training or a hospice certification program within 12 months of hire. All management personnel must complete 20 hours of new hire orientation within 60 days and 12 hours of annual training covering hospice policies, procedures, patient care, fraud prevention, controlled substance management, and regulatory compliance. Management personnel employed before the regulations take effect are exempt from the new hire orientation requirement.

### **Key Takeaways**

These are California’s first-ever comprehensive hospice licensing regulations. They are broad in scope and reflect the state’s efforts to combat fraud in the hospice industry. Key takeaways for hospice providers and investors include:

- **Compliance Review and Operational Restructuring:** Hospice providers should begin assessing their operations for compliance with the Proposed Regulations' requirements, such as the 12:1 nurse-to-patient ratio, the county-level unmet need formula, and the concurrent employment limits for management personnel.
- **Plan Transactions to Account for CHOW Changes:** For hospice providers and investors considering sales or acquisitions, the five-year CHOW moratorium reset and substantial changes to hospice CHOW requirements will require careful transaction planning and longer lead-times.
- **Don't Forget the Feds:** The Proposed Regulations arrive alongside aggressive federal enforcement in the form of CMS's PPEO audits, affiliation-based revocations, and nationwide enrollment moratorium. Hospice providers should preemptively prepare for potential PPEO review, limit unnecessary affiliation exposure, and establish a revocation response plan.

Although these are emergency regulations and therefore temporary, CDPH has indicated it will pursue a regular rulemaking to make these requirements permanent. CDPH is accepting public comments during a five-calendar-day window from June 11 through June 16, 2026. Stakeholders who wish to provide input should act immediately. We are available to assist interested stakeholders who wish to provide comments, and we will continue to monitor developments as CDPH moves toward finalizing these Proposed Regulations.

#### **RELATED CAPABILITIES**

[Medicare and Medicaid Audits, Appeals, and Reimbursement Litigation](#)

[Medicare, Medicaid, Other Governmental Reimbursement and Payment](#)

[Business Transactions](#)

[Government Investigations](#)

[Mergers and Acquisitions](#)

[Hospice](#)