



POLICY & COMPLIANCE INSIGHTS

California's New Hospice Emergency Regulations

What DPH-18-002E means for patients, providers, and the future of hospice care in California

A HealthBridge Summary of the California Department of Public Health
Finding of Emergency — Regulation Package DPH-18-002E, June 2026

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Executive Summary

In June 2026, the California Department of Public Health (CDPH) issued emergency regulations for hospice agencies under DPH-18-002E — the first comprehensive regulatory framework the state has ever adopted for this sector. The rules respond directly to a 2022 State Auditor investigation that uncovered widespread indicators of fraud, abuse, and neglect concentrated in Los Angeles County, and to a legislatively mandated licensing moratorium that has been in place since 2021.

For hospice operators and the broader HealthBridge community, these regulations mark the end of an era of minimal oversight and the start of a far more rigorous licensing, staffing, and enforcement environment. This brief distills the 143-page regulatory package into the statistics, standards, and timelines that matter most to operators, referral partners, and patient families.

Why It Matters

- Closes a five-year-old licensing moratorium with a clear, permanent-track regulatory framework.
- Introduces California's first-ever nurse-to-patient staffing ratio for hospice case managers.
- Establishes geographic service area limits to stop oversaturation and “paper” hospice schemes.
- Tightens ownership, background-check, and management-oversight requirements to prevent identity theft and shell operators.

“Hospice fraud preys on people at their most vulnerable — not just wasting public dollars, but robbing families of dignity, peace, and security.” — CDPH, Finding of Emergency

Key Numbers at a Glance

Seven statistics that capture the scale of the problem — and the scope of the fix.

27

hospice agencies managed by a single administrator

4 vs 56

avg. patients per hospice, LA County vs rest of CA

1:12

new statewide nurse-to-patient staffing ratio

25

counties defined as rural areas eligible for flexibility

60

days to fill a vacant DPCS position

24

months an applicant must wait after a revocation

2 hrs

maximum travel time for a geographic service area

4 yrs

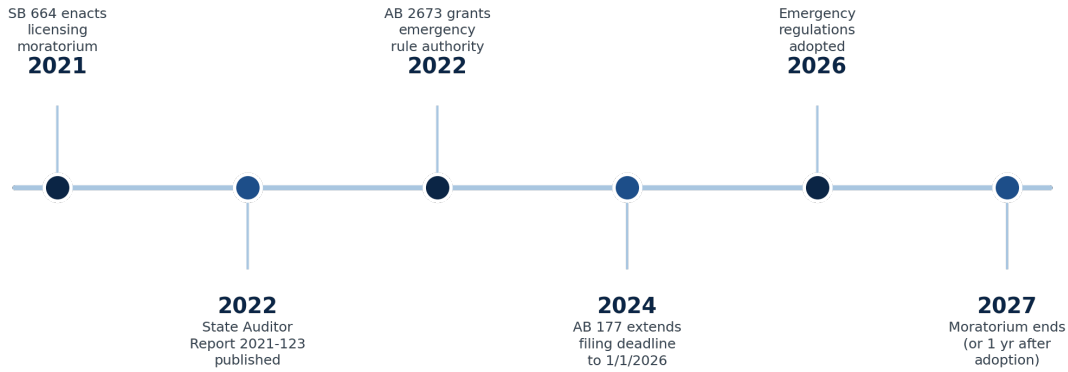
minimum personnel record retention period

28

new sections added to Title 22 of the CCR

The Crisis Behind the Regulations

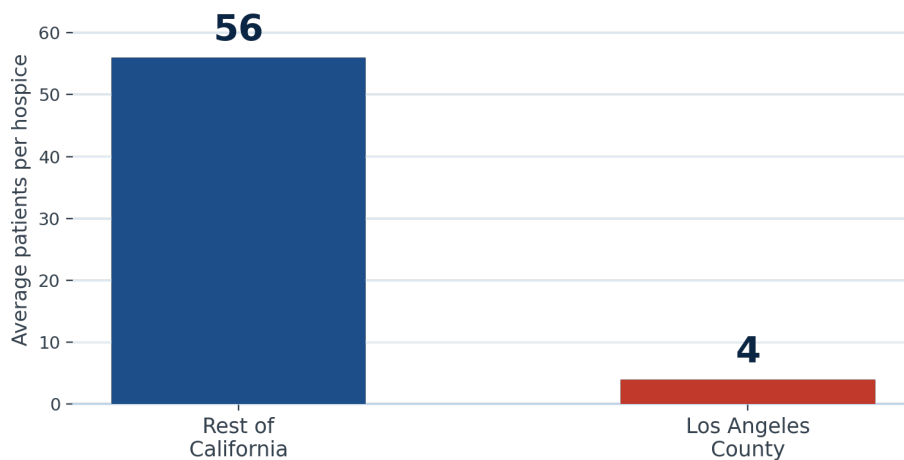
California's hospice oversight gap did not emerge overnight. A chain of legislative and investigative actions over five years set the stage for this month's emergency rulemaking.



The 2022 Audit Findings

The California State Auditor's 2022 report (2021-123) substantiated significant concerns about fraud and abuse in the hospice program, with the sharpest indicators concentrated in Los Angeles County. The Auditor found a striking statistical anomaly: hospices outside LA County served an average of 56 patients, while hospices inside LA County averaged just 4 — a pattern consistent with clusters of fictitious agencies enrolling patients without their knowledge and billing Medicare for services never provided.

A Statistical Red Flag for Fraud



Six Documented Indicators of Fraud

The Legislature directed CDPH to address six specific fraud indicators identified in the Audit Report through emergency rulemaking authority under Health and Safety Code section 1753.1.



What the Regulations Establish

The emergency package adds 28 new sections to Title 22 of the California Code of Regulations, organized into five articles covering definitions, licensing applications, geographic service areas, personnel standards, and patient care requirements.

Article 1	Definitions — standardizes dozens of hospice-industry terms drawn from federal CFR, state statute, and CHAPCA standards.
Article 2	Licensing Applications — new screening, ownership disclosure, and background-check requirements for applicants.
Article 3	Geographic Service Areas — caps service areas and requires a documented “unmet need” before entry into a county.
Article 4	Personnel Standards — staffing ratios, management oversight limits, and mandatory screening/training.
Article 5	Patient Care & Business Practices — record-keeping, confidentiality, and operational transparency requirements.

Key Definitions Worth Knowing

- Beneficial Ownership Interest — now captures indirect ownership stakes above 5%, closing a loophole used to obscure true control of an agency.
- Geographic Service Area (GSA) — the county or counties CDPH approves for a hospice to operate in, based on a documented unmet-need calculation.
- Director of Patient Care Services (DPCS) — the clinical leader responsible for a hospice's nursing program, now limited to overseeing a single agency.
- Authorized Individual — clarified list of who may access patient medical information, aligned with the Confidentiality of Medical Information Act.

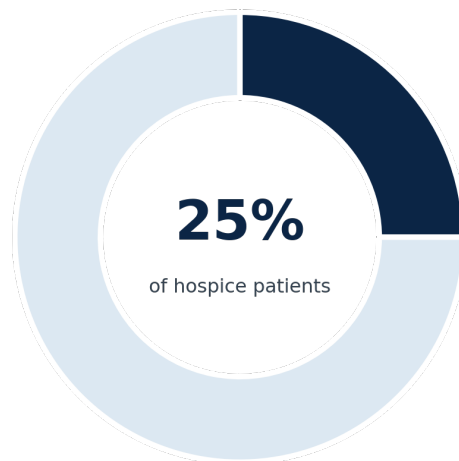
Raising the Bar on Patient Care

For the first time, California will enforce a statewide nurse-to-patient staffing ratio for hospice case managers — a standard that simply did not exist in state or federal law before this rulemaking.

CDPH considered a 2022 industry study showing average caseloads of 13–18 patients per registered nurse case manager, alongside National Hospice and Palliative Care Organization data showing a historical median of 12. After stakeholder input — including concerns about nurse burnout amid a broader nursing shortage — the Department set the new standard at 12 patients per nurse.

Clinical Complexity Is Rising

Hospice patients today often present with more complex needs than in years past. Department subject matter experts noted that a meaningful share of the hospice population requires specialized clinical protocols.



An estimated 25% of hospice patients have a substance use disorder, reinforcing the need for updated federal- and state-aligned confidentiality and clinical protocols built into the new patient care standards.

Protections for Patients & Families

Beyond staffing and licensing standards, the emergency regulations codify a series of protections aimed directly at the patients and families hospice agencies serve during the final stage of life.

Advance Directive Information

Hospice agencies must provide the patient or the patient's representative with written information at the time of admission describing the agency's advance directive policies, the benefits of completing an advance directive, and the patient's right to refuse treatment. Because hospice patients are, by definition, in the last stage of life, clear and timely information about these rights is treated as a core patient-safety requirement rather than an administrative formality.

Bereavement Services

Consistent with Health and Safety Code section 1746(a), hospices remain required to provide bereavement services — grief and bereavement counseling and care planning support — to the families of patients they serve, reinforcing that hospice care extends beyond the patient to the family unit.

Confidentiality & Complex Clinical Needs

With an estimated 25% of hospice patients living with a substance use disorder, the new regulations weave together federal confidentiality protections under Title 42 and California confidentiality law, giving hospice staff clearer guidance on protecting sensitive patient information while still coordinating appropriate clinical care.

A More Accountable Industry

Taken together, the licensing, staffing, geographic, and enforcement provisions in DPH-18-002E are designed to ensure that when a family chooses a hospice agency, that agency has been vetted, its management is qualified and limited in scope, its nurses carry a sustainable caseload, and its service area reflects genuine community need — not opportunistic billing.

Tighter Rules for Management & Ownership

The Audit Report's most striking finding was a single administrator managing 27 separate hospice agencies — far more than any individual could reasonably oversee. The new regulations respond directly to this pattern.

Director of Patient Care Services (DPCS) — One-Agency Rule

- A DPCS may oversee and be responsible for only one hospice agency.
- A limited exception allows a rural-area DPCS to manage one additional hospice within the same rural region.
- If the DPCS role becomes vacant, the hospice must fill it within 60 days to keep clinical oversight uninterrupted.
- Individuals with disqualifying disciplinary history within the past seven years may not serve as a DPCS.

Ownership & Screening Requirements

- Beneficial ownership interests above 5% must be disclosed, including indirect and combined stakes.
- Personnel and contractors must be screened against federal and state exclusion lists before hire and monthly thereafter.
- Initial and periodic conflict-of-interest disclosures are required to deter referral kickbacks and billing fraud.
- Personnel records must be retained for at least four years after separation and made available to Department surveyors without delay.

“One administrator managed 27 agencies. Others used the names and personal information of individuals who were not actually employed.” — CDPH Finding of Emergency, citing the 2022 Audit Report

Geographic Service Areas: Ending Oversaturation

Before these regulations, hospices could claim service areas so large they could not realistically deliver timely care — or so saturated with competing agencies that fraud could hide in the noise. The new geographic service area (GSA) framework addresses both problems.

How the Unmet-Need Calculation Works

- CDPH will use CalHHS mortality data to estimate the terminally ill population likely eligible for hospice care in each county.
- The total number of currently licensed hospices in a county is multiplied by the statewide average of 56 patients per hospice to estimate existing capacity.
- A county only qualifies for new hospice entry when documented need exceeds existing capacity — helping prevent further oversaturation in high-risk areas like Los Angeles County.
- New GSAs must fall within a two-hour travel-time standard so patients receive timely, in-person care.

Rural Counties Get Targeted Flexibility

Twenty-five counties are defined as rural areas under the new regulations, reflecting their lower population density. Rural hospices receive specific accommodations — such as the DPCS dual-agency exception — recognizing that strict urban standards could otherwise make it difficult to recruit and retain qualified management in less populated regions.

Fiscal Impact & Implementation

CDPH's economic impact assessment found the emergency regulations to be narrowly scoped in direct state cost, while creating substantial compliance obligations for the regulated community.

Cost to local agencies or school districts	None identified
Cost to state agencies	\$5,098 per affected state-run hospice facility (\$10,196 total for two facilities), absorbed within existing budgets
Federal funding impact	None identified
Mandated by federal law	No — California's standards exceed the federal minimum

What Happens Next

- The Office of Administrative Law allows a five-calendar-day public comment period after CDPH's submission of the emergency action.
- Once adopted, the regulations remain in effect through the end of the hospice license moratorium.
- CDPH intends to pursue a regular (non-emergency) rulemaking process to make these standards permanent.
- The licensing moratorium is scheduled to end January 1, 2027, or one year after the emergency regulations are adopted — whichever comes sooner.

Enforcement: Denials, Suspensions & Revocations

Section 74832 gives CDPH surveyors clear, enforceable grounds to deny a hospice license application — closing gaps that previously allowed questionable operators to obtain licensure with minimal scrutiny.

Grounds for Denial

- Failure to meet any requirement of Chapter 6.5 or applicable Health and Safety Code sections.
- Failure to meet Medicare Conditions of Participation under Title 42 CFR, for applicants electing Medicare participation.
- Failure to fully implement an approved Plan of Correction after a prior survey finding.
- Recent license revocation or suspension — applicants must wait 24 months before reapplying.
- An incomplete application, or failure to remediate discrepancies after a Department request.
- A proposed geographic service area that does not demonstrate documented unmet need, to prevent clustering and oversaturation.
- Unpaid licensing fees required under Health and Safety Code section 1266.

Why a 24-Month Waiting Period

The 24-month reapplication waiting period after a license revocation or suspension mirrors existing Title 22 standards for Home Health Agencies under HSC section 74671(b)(2). CDPH determined this window gives a previously noncompliant operator time to correct underlying issues before being trusted with vulnerable patients again — while still preserving a path back into the industry for operators who can demonstrate reform.

“Approving an application that does not meet the basic requirements would pose a risk to the health and safety of hospice patients.” — CDPH, Section 74832 rationale

How California Compares

Hospice licensure has historically been governed more by Medicare Conditions of Participation than by state-specific rules. In building DPH-18-002E, CDPH researched how other states structure their own hospice oversight, and found California's approach — particularly its unmet-need GSA framework and one-agency DPCS rule — to be among the most rigorous in the country.

Mississippi	Prohibits a Director of Nursing from simultaneous employment at more than one hospice agency — a narrower precedent for California's new DPCS one-agency rule.
New York	Uses a formal “public need” determination methodology for new hospice licensure, conceptually similar to California's new unmet-need GSA calculation.
Florida	Regulates hospice service areas through its Certificate of Need program, restricting new entrants where existing capacity is deemed sufficient.
Federal (CMS)	Sets baseline Conditions of Participation but currently imposes no nurse-to-patient staffing ratio and no cap on the number of agencies one administrator may oversee.

California's emergency regulations go beyond the federal floor in nearly every category — staffing ratios, management oversight limits, and geographic saturation controls all exceed what CMS currently requires nationally.

Frequently Asked Questions

Q. Does this affect hospices outside Los Angeles County?

A. Yes. While the Audit Report's most severe fraud indicators were concentrated in LA County, the regulations apply statewide to every licensed and applicant hospice agency in California.

Q. When do the new staffing ratios take effect?

A. The 1:12 nurse-to-patient standard takes effect when the emergency regulations are adopted, following the Office of Administrative Law's five-day public comment period after CDPH's submission.

Q. What happens to the licensing moratorium?

A. The moratorium on new hospice licenses, in place since 2021, is scheduled to end January 1, 2027, or one year after the emergency regulations are adopted — whichever comes first.

Q. Are these rules permanent?

A. Not yet. They are adopted on an emergency basis to address an urgent public health and fraud concern. CDPH intends to pursue a regular rulemaking process afterward to make the standards permanent.

Q. What should a hospice do first?

A. Start with a staffing and management audit: confirm nurse caseloads, DPCS agency count, and ownership disclosures all align with the new standards, since these are the areas most directly tied to the Audit Report's findings.

What This Means for Providers

Legitimate hospice operators — including organizations that have long invested in qualified staffing and transparent business practices — stand to benefit from a more level playing field. At the same time, the compliance runway is short, and every licensed and applicant hospice should begin preparing now.

Readiness Checklist

- Confirm nurse case manager caseloads align with the new 1:12 staffing standard.
- Verify your DPCS is not serving more agencies than the new one-agency rule (or rural exception) allows.
- Review beneficial ownership disclosures for accuracy, including indirect ownership stakes above 5%.
- Audit personnel files for complete background screening, exclusion-list checks, and conflict-of-interest disclosures.
- Reassess your geographic service area against the new unmet-need and two-hour travel-time standards.
- Update personnel record retention practices to meet the four-year minimum.

Conclusion

DPH-18-002E represents the most significant regulatory shift the California hospice industry has seen in over three decades. While the compliance bar is higher, the intent is clear: protect patients in their most vulnerable moments and restore integrity to a program the State Auditor found was being exploited at scale. HealthBridge will continue to track implementation guidance from CDPH and share updates as the emergency regulations move toward permanent adoption.

Source: California Department of Public Health, Finding of Emergency — Emergency Regulations for Hospice Agencies (DPH-18-002E), June 1, 2026.

Appendix: Key Terms Glossary

A quick reference to the hospice-specific terminology introduced or standardized under Article 1 of the emergency regulations.

Administrator	An individual appointed in writing by the governing body of the hospice to organize and direct its services and functions.
Administrator Designee	An individual appointed to assume the Administrator's responsibilities when the Administrator is unavailable.
Beneficial Ownership Interest	Direct or indirect ownership stakes above 5% (and below 50%) in a hospice, or in obligations secured by hospice assets or property.
Comprehensive Assessment	A patient evaluation meeting the standard set forth in Title 42 CFR section 418.3.
Director of Patient Care Services (DPCS)	The clinical leader responsible for a hospice's nursing program; now limited to overseeing one agency (with a rural exception).
Geographic Service Area (GSA)	The county or counties CDPH approves for a hospice to operate in, based on a documented unmet-need calculation.
Plan of Correction	A hospice's documented response to survey findings, describing how identified deficiencies will be remedied.
Rural Area	One of 25 California counties defined by population density, eligible for targeted regulatory flexibility.
Unmet Need	The gap between the terminally ill population likely eligible for hospice care in a county and the capacity of currently licensed hospices to serve them.

About This Summary

This document was prepared by HealthBridge as an educational summary of the California Department of Public Health's Finding of Emergency for DPH-18-002E (Emergency Regulations for Hospice Agencies), issued June 1, 2026. It is intended for general informational purposes and does not

constitute legal advice. Hospice operators should consult the full regulatory text and qualified legal counsel to confirm compliance obligations specific to their agency.

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Staying ahead of the regulations that shape hospice care.

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Source: CDPH Finding of Emergency, DPH-18-002E, June 1, 2026.