



# 2026 ANNUAL **CONFERENCE & EXPO**

**Celebrating 60 Years**

● Then. Now. Next. ▲

## **Regulations Bring Opportunities**

*What was then, current, and our future!*

**June 22, 2026**



# Objectives

1. Major changes in the regulations, what is new and what is proposed.
2. Understand the comprehensive creation of higher standards for orientation and ongoing education guidelines
3. Recognize opportunities to thrive, driven by the regulations



**“Fasten your seatbelts, it's going to be a bumpy ride”**

Betty Davis 1950 “All About Eve”



**2026 Annual Conference & Expo**

# Regulatory Changes

CA Emergency Regulations

CA Medi-Cal Requirements

CMS Proposed Rule

Service and Spending Variation Index-  
"SSVI"

PEPPER Report

National Moratorium

Fraud Task Force

CMS Payment Suspensions



# How did we get here?

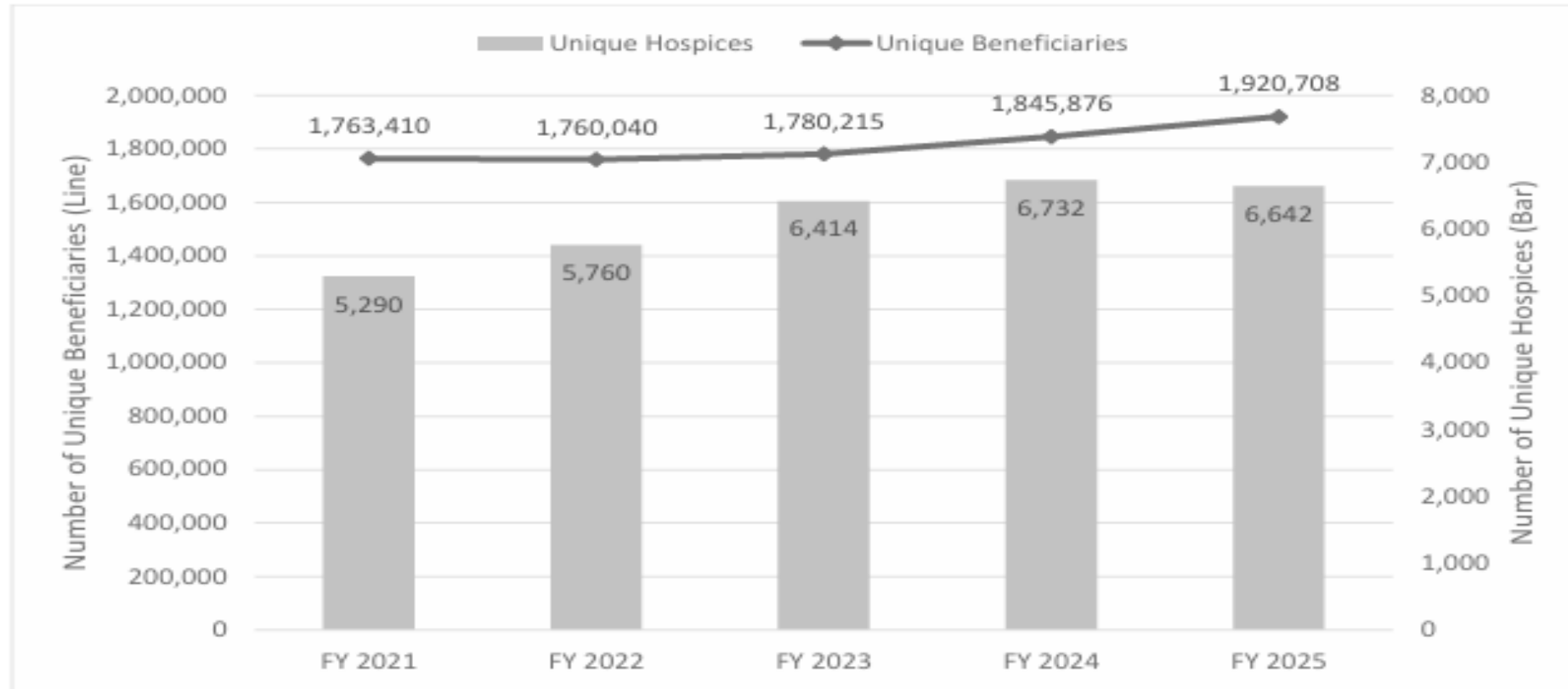


- Growth in Hospice Organizations & Beneficiaries Served
- Increasing nationwide Medicare Hospice expenditures
- Increasing Length of Stays greater than 180 days
- Medicare Non-Hospice Spending for Medicare Hospice Users
- Increased media reporting on Hospice inadequate quality of care and fraud.



# REFERENCE

## Exhibit 1. Overall Utilization of Hospice Services



Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)



## REFERENCE

### Exhibit 6. Medicare Hospice Expenditures for FYs 2021-2025

	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>	<b>FY 2024</b>	<b>FY 2025</b>
<b>Total Hospice Payments</b>	\$23,034,467,018	\$23,454,108,667	\$25,118,832,135	\$27,632,500,645	\$30,251,623,171
<b>Unique Beneficiaries</b>	1,763,410	1,760,040	1,780,215	1,845,876	1,920,708
<b>Days of Hospice</b>	128,931,875	131,235,196	138,407,166	148,193,906	156,846,614
<b>Average (mean) Payments per Beneficiary</b>	\$13,062.46	\$13,325.90	\$14,110.00	\$14,969.86	\$15,750.25
<b>Average (mean) Payments per Day</b>	\$179	\$179	\$181	\$186	\$193

*Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)*



## REFERENCE

### Exhibit 5b. Percentage (within a year) of Beneficiaries by Hospice Lifetime Length of Stay (LOS) Category for FYs 2021-2025

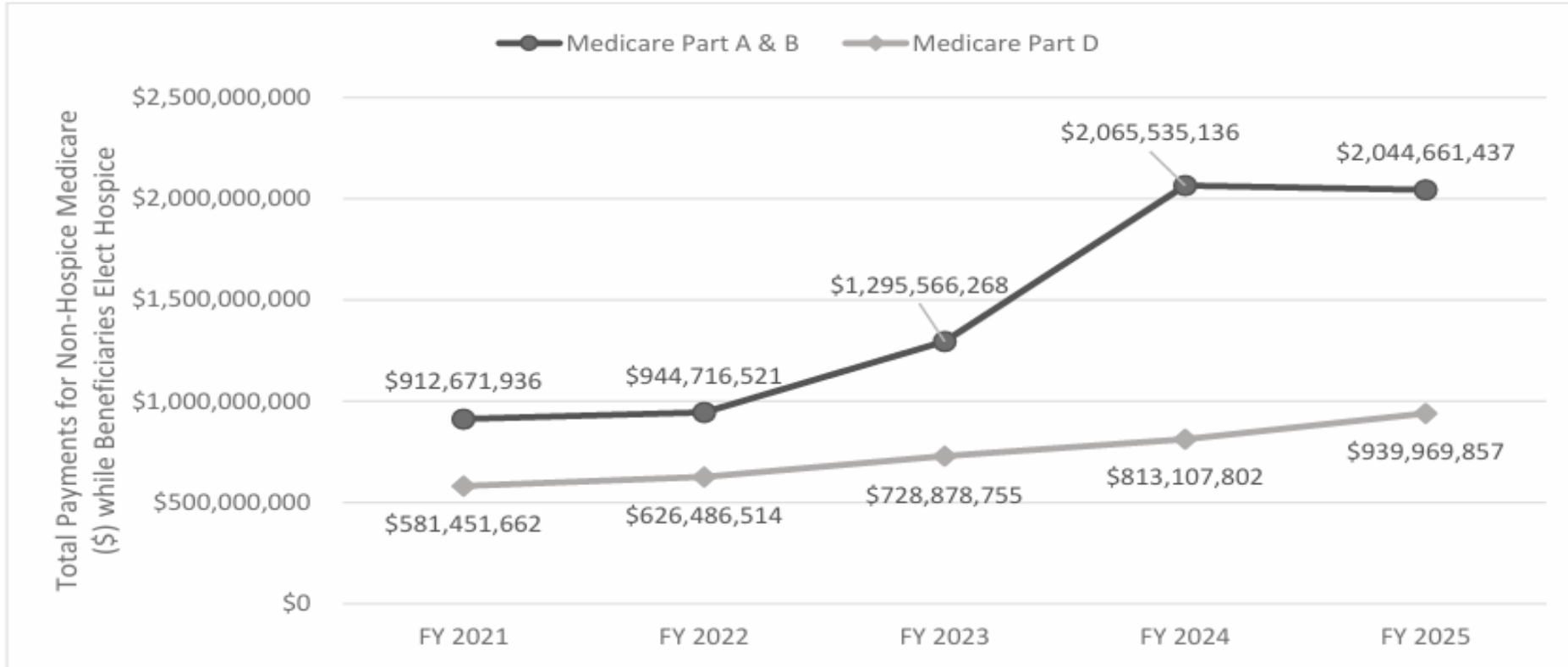
Hospice Lifetime LOS	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
1-4 days	23.0%	22.3%	21.5%	21.1%	20.4%
5-10 days	18.1%	17.7%	17.4%	17.0%	16.4%
11-30 days	19.4%	19.5%	19.4%	19.1%	18.7%
31-60 days	10.6%	10.9%	11.0%	10.9%	10.9%
61-90 days	5.6%	5.8%	5.9%	6.0%	6.0%
90-180 days	8.9%	9.2%	9.5%	9.7%	10.0%
181+ days	14.5%	14.6%	15.2%	16.2%	17.6%

Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)



## REFERENCE

### Exhibit 7. Medicare Non-Hospice Spending for Medicare Hospice Users for FYs 2021-2025



*Analyses of Medicare FFS claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)*



# This did not happen overnight!



2026 Annual Conference & Expo

- Arizona
- Nevada
- Texas
- Georgia
- Ohio
- More to come ....

**It's not just  
California ...OIG  
and DOJ -  
Findings**



# OIG and DOJ Findings

- **Kickbacks** to recruiters for patient referrals
- Recruiters **enticing** patients with “free” hospice care, cash, groceries, or DME (hospital beds, scooters, etc.)
- **Not telling patients** they are signing up for hospice (*e.g.*, telling patients or family members the forms are for home health) or telling patients that hospice covers non-terminal conditions
- Staff **falsely diagnosing** patients with conditions they do not have and **falsifying** medical records
- Doctor **falsely certifying** patients as terminally ill





- Claims data analysis

- Discharge/death rates
  - Compare to nationwide non-death discharge rate (**15.4% in 2020**)
- Length of stays
- Attending physicians
- Geographic area (e.g., far away from hospice)
- Beneficiaries have same/close address(es) (e.g., same complex, building)
- Married couples (same last names, address)
- Same admit/discharge date for multiple beneficiaries
- Cycling patients (home health → hospice → home health → *repeat*)



- Medical Records
  - Missing documentation
  - Copy and paste
  - Lack of individual treatment plans
  - Impossible numbers (one nurse in multiple places at once)



# Where this Began .....

## CA Hospice Licensure and Oversight Audit Report

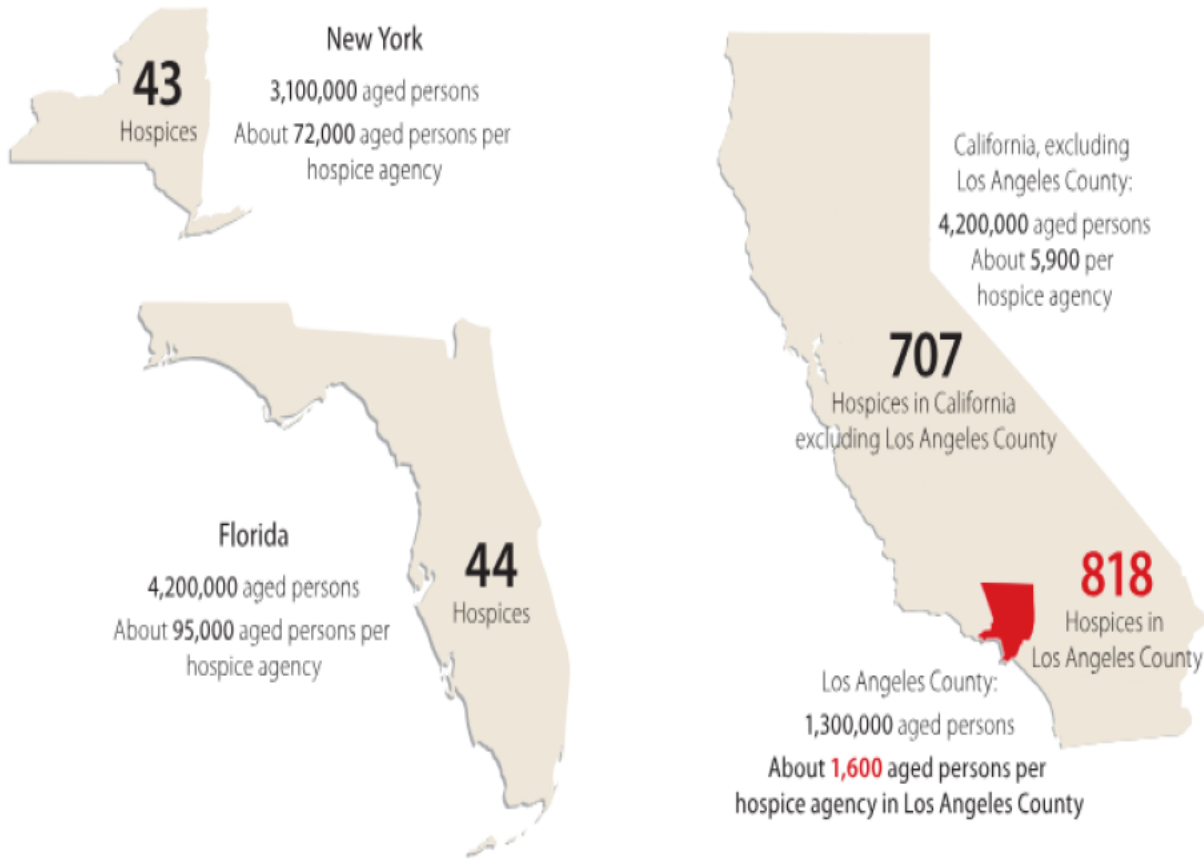
### March 29,2022

#### Audit Highlights...

- Los Angeles County has experienced a 1,500 percent increase in its number of hospice agencies since 2019.
  - It had more than six-and-a-half times the nationwide average number of hospice agencies relative to its aged population in 2019.
  - Excessive geographic clustering of hospices (dozens in same building)
- We found indicators of large-scale fraud that include likely fraudulent billing to Medicare and Medi-Cal and the apparent use of stolen identities of medical personnel to obtain licenses.
  - Unusually long length of stays
  - High rates of still-living patients discharged from hospice



# In 2019:



New York and Florida each have laws requiring hospice agencies to demonstrate a need for services in areas in which they wish to operate.

Los Angeles County has 45 times as many hospice agencies as New York and 59 times as many agencies as Florida when considering aged populations.

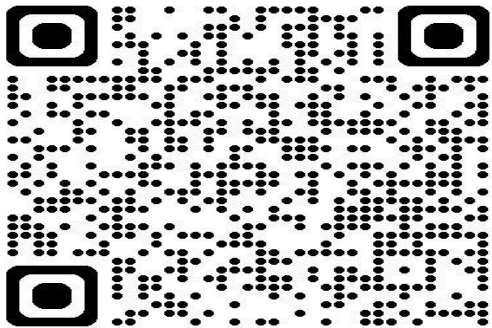
## REFERENCE

Source: Auditor of the State of California, "California Hospice Licensure and Oversight," Report 2021-123 (March 2022), at 20, available at <https://www.auditor.ca.gov/pdfs/reports/2021-123.pdf>.

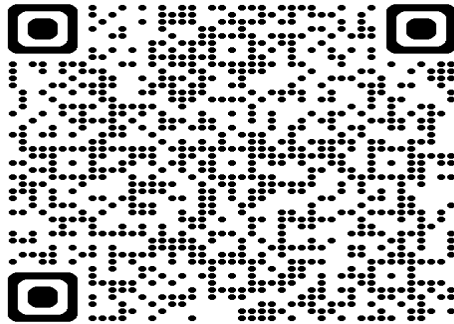


# Regulatory Changes

- California AB 2673 — Hospice Agency Licensure and Change of Ownership Rules: AFL 22-28
- California Proposed Emergency Regulations: All Facilities Letter (ALF) 25-29
- **Hospice Agencies 5-Day Notice of Proposed Emergency Regulatory Act:**
  - **DPH 18-200E (ALF-26-18) June 4, 2026**



AB 2673 AFL 22-28 (NOV 2022)



Proposed Regulations (NOV 2025)



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**[https://  
www.cdph.ca.gov/  
Programs/OLS/CDPH  
Document Library/  
DPH-18-002E\\_FOE.pdf](https://www.cdph.ca.gov/Programs/OLS/CDPH/Document%20Library/DPH-18-002E_FOE.pdf)**  
[www.cdph.ca.gov](http://www.cdph.ca.gov)

Emergency Regulations June 4, 2026



# California AB 2673 Chapter 797, Statutes of 2022) – Expansion of Hospice Agency License Requirements, Oversight, and Enforcement AFL 22-28 11/29/22

## REFERENCE

### Moratorium

- Extends the moratorium on new hospice licensure until the California Department of Public Health (CDPH) adopts emergency regulations for hospice agencies, but no later than March 29, 2024

### Management Personnel

- Specifies mandatory management personnel and requires currently licensed hospice agencies to submit information by March 31, 2023, at initial application, and any time there is a change of management personnel

### Expanded Grounds for Denial, Suspension, or Revocation

- New grounds include:
  - Improperly certifying a patient as eligible for hospice care.
  - Demonstrating a **pattern and practice** of violations of state or federal standards in the last three years

### CHOW Timing

- A hospice agency may only CHOW **five years after** its license was initially issued to the current licensee
- If a CHOW occurs before that time without CDPH approval, the current licensee's license can be revoked, and the new operator will not be issued a license

### Unmet Need Requirement

- Applicants without prior licensure must demonstrate and provide evidence of an **unmet need** of hospice services in the geographic area they would serve

### Validation Surveys

- CDPH must conduct annual surveys of **5%** of initial hospice agency licenses approved by accrediting organizations in the prior calendar year

### Complaints

- Establishes a complaint process



# AB 2673 requires CDPH to adopt Emergency Regulations:

## REFERENCE

- Implement recommendations in the CA State Auditor Report 2021-2023
- Regulations must **establish**:
  - Maximum time and distance standards for staff to travel to patients
  - Nurse to patient ratios
  - Hospice agency office space requirements
  - Timeliness for reporting changes

**and**

  - Limit the number of hospice agencies that management can be involved with concurrently
  - Require management to meet a minimum standards of training and experience
  - Established Administrator, Medical Director and Director of Patient Care Services Designees



# CAHSAH Advocating for Hospice DPH Stakeholder Meetings

**14 Mar. 2023**

Discussion of development of emergency regulations. Questions for stakeholder meeting sent (AFL 23-14).

CAHSAH presented responses to questions.

**28 Feb. 2024**

SB 137 Extends deadline for CDPH adoption of emergency regulations until January 2025.(AFL 24-10)

**3 Nov. 2025**

CDPH Stakeholder meeting to discuss proposed regulations. Hospice Regulation Text sent (AFL 25-29). CAHSAH responded to regulations.

**May 2026**

CDPH/CAHSAH meeting. CDPH to publish and adopt emergency regulations in June 2026. Comment period will follow and final regulations published after review of comments in 2026.

Discussion of development of emergency regulations. Questions included for discussion (AFL 23-31).

CAHSAH presented responses to questions.

**13 Oct 2023**

AB177 Extends deadline for CDPH to adopt emergency regulations until January 2026. (AFL 25-04).

Requiring minoritarian on new hospice agencies license to end, January 2027 one-year after adoption of emergency regulations.

**3 Feb. 2025**

CDPH submitted the withdrew adoption of emergency regulations

**Jan. 2026**

CAHSAH developed comments on Emergency Regulations for submission to CDPD

**June 11th, 2026**



# Hospice Agencies 5-Day Notice of Proposed Emergency Regulatory

**Act: DPH 18-200E (ALF-26-18) June 4, 2026**

- **Five-Day Comment Period:**
  - **Start of Comment Period: June 11, 2025**
  - **End of Comment Period: June 16, 2026**
  - **Effective Date of Emergency Regulations:**

**TODAY**



Don't let this  
be you?



# California Emergency Regulations Changes: DPH-18-002E, Hospice Agencies, Content as of 6/4/2025

## Hospice Title 22- **New Regulations 2026 and Beyond**

### Categories:

- Section: 74800: Definitions
- Section: 74804: General Licensing Requirements
- Section: 74808: Inspection
- Section: 74812: Content of Application (Medical has unique requirements)
- Section: 74816: Licensing Fees
- Section: 74820: Geographic Service Areas
- Section: 74824 Change of Ownership
- Section 74828 Report of Changes
- Section 74832 Denial of Application
- Section 74836 Renewal and Expiration
- Section 74840 Voluntary Cancelation of License
- Section 74844 Involuntary License Suspension, Revocation and Reinstatement



# California Emergency Regulations Changes:

## Hospice Title 22- **New Regulations 2026 and Beyond**

- Section: 74848 Nursing
- Section: 74856 Medical Director
- Section: 74860 Admission
- Section: 74864 Assessment
- Section: 74868 Plan of Care
- Section 74872 Plan of Care – Review
- Section: 74876 Administrator
- Section 74880 Hospice Management
- Section: 74884 Personnel Records
- Section: 74888 Medical Record Services
- Section 74892 Medical Record Content
- Section: 74896 Medical Record Use and Access
- Section 74900 Electronic Health Records
- Section::74908 Hospice Office Space
- Section: 47904 Plan of Correction



# Section 74800: 36 New Definitions

## Words

Addendum

Administrator Designee

Applicant

Application

## Authenticate

Authorized Individual

## Beneficial Ownership interest

Business Entity

Business Hours

Comprehensive Assessment

Day

Director of Patient Care Services

Director of Patient Care Services Designee

## Double Billing or "excessive billing"

Electronic Health Record

## Entity

Established place of business

Geographic Service Area

Hospice Management Personnel

Hospice Services

## Immediate family

Immediate Jeopardy

Initial Assessment

Involuntary Suspension

## Medical Director Designee

Medical Record

## Ownership Interest

Patient's Representative

Personnel

Plan of Care

Primary caregiver

## Rural Area (25 Counties)

## Significant Business Transaction

Subcontractor

Unmet Need

## Upcoding



# California Proposed Emergency Regulations Changes

## Section: 74800: Definitions

**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.

**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.

**“Parent hospice”** or “parent agency” has the meaning set forth in Health and Safety Code section 1746(k).

### Health and Safety code 1747:

“**Parent agency**” means the part of the hospice that is licensed pursuant to this chapter and that develops and maintains administrative control of multiple locations. All services provided from each multiple location and parent agency are the responsibility of the parent agency.

“**Multiple location**” means a location or site from which a hospice makes available basic hospice services **within the service area of the parent agency.** A multiple location shares administration, supervision, policies and procedures, and services with the parent agency in a manner that renders it unnecessary for the site to independently meet the licensing requirements.



# Section 74812: Application



Number of hours that will be spent in the hospice by the Administrator and Administrator Designee each week

If concurrently employed by multiple hospices in a rural area, **the number of hours that will be spent at each hospice per week.**



Proof that the Medical Director is certified as a hospice medical director according to the requirements established by the Hospice Medical Director Certification Board or Board certified by the American Board of Medical Specialties or American Osteopathic Association **if the Medical Director holds such certification.**



# Section: 74808: Inspection

- Hospice is Subject inspections by CDPH prior to license, & during licensure
- Unannounced and at any time
- Hospice must:
  - Provide access to hospice by CDPH. **Failure to provide access subject to denial, suspension, or revocation of hospice license**
  - Make available all requested written and electronic documents, forms, records, or files for CDPH to inspect, photocopy or scan.
  - Provide all necessary passwords & authorization for CDPH to access electronic records
- Interview patients, patient representatives, hospice applicant or licensee, governing body, hospice owners, officials & management personnel
- On-site observation of patient care at site of care



# Section: 74820 Geographic Service Area

- Hospice MUST GUARANTEE that a licensed “nurse” appears in person 24 hours a day, 7 days a week to provide services within 2 hours of receiving information that a patient is in need of care or if a safety concern exists.
  - Compliance Note:
    - Federal rules = RN available 24 hours/day, You cannot service after hour needs with ONLY LVN's
    - How do we define “need” or “safety concern”?
- Policies and Procedures are required to be developed and maintained to ensure patients can receive “support” UNTIL a licensed nurse can appear in person
  - Compliance Note:
    - Define Support provided until a visit occurs: On call phone support, use of PRN meds, etc.
    - Are you tracking the service delivery time, Call received vs. Visit time?
    - Are you receiving a Night Report? Are you providing a night report to on-call staff?
    - Are you tracking day time concerns too?
- Must receive written approval by CDPH prior to services initiated, advertised or provided. Changes, or initial applications



# Section: 74820 Geographic Service Area

- Hospice Must Calculate Geographic Service Area. Must be Defined in a policy.
  - 2-hour service territory from PARENT HOSPICE, “Mile Radius”
  - Documentation is required:
    - 4 distance value “samples”
      - Google/Waze?
    - During 7-9 AM OR 4-6 PM (You can select one or the other times)
    - Must Attempt your samples during “NON-HOLIDAY” WEEKDAY
    - Must timestamp your sample attempts and maintain these records
    - Take the average miles able to be driven to establish your “radius” in miles
    - Must Maintain a “Map” to show the Geographic Service area
    - The names and zip codes of all counties to be served by the hospice is also required to be documented
    - If adding “multiple” locations, these locations geographic service area is within the “parents” office radius
    - Geographical Service area must only include counties that have an “unmet” need.



# Geographic Service Area-Calculating Un-met Needs

## Method and Data Source:

- CA Health and Human Services Agency Open Data Portal..... “**Final Deaths by Year by County**” via the “Death Profiles by county” webpage and Filter the columns as indicated below.....
- **Years column** = “all available years”
- **County Column** = Select only the “primary county” your parent hospice address has on your application for licensure
- **Geography Type column** = “residence”
- **Strata Column** = “total Population”
- **Cause column** = “CAN” (deaths due to cancer)
- **Count** = Add together all CANCER Deaths



# Geographic Service Area-Calculating Un-met Needs

https://data.chhs.ca.gov/dataset/death-profiles-by-county

CalHHS

Datasets Topics Departments Portal Metrics Geoportal Training

Home / Departments / California Department of... / Death Profiles by County

Death Profiles by County

Sign up for email updates:

Email Address

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Department

CDPH  
California Department of Public Health

California Department of Public Health

The California Department of Public Health (CDPH) works to protect the public's health in the Golden State and helps shape positive health outcomes for individuals, families and...

[read more](#)

Social

Dataset Topics Showcases Activity Stream

## Death Profiles by County

This dataset contains counts of deaths for California counties based on information entered on death certificates. Final counts are derived from static data and include out-of-state deaths to California residents, whereas provisional counts are derived from incomplete and dynamic data. Provisional counts are based on the records available when the data was retrieved and may not represent all deaths that occurred during the time period. Deaths involving injuries from external or environmental forces, such as accidents, homicide and suicide, often require additional investigation that tends to delay certification of the cause and manner of death. This can result in significant under-reporting of these deaths in provisional data.

The final data tables include both deaths that occurred in each California county regardless of the place of residence (by occurrence) and deaths to residents of each California county (by residence), whereas the provisional data table only includes deaths that occurred in each county regardless of the place of residence (by occurrence). The data are reported as totals, as well as stratified by age, gender, race-ethnicity, and death place type. Deaths due to all causes (ALL) and selected underlying cause of death categories are provided. See temporal coverage for more information on which combinations are available for which years.

The cause of death categories are based solely on the underlying cause of death as coded by the International Classification of Diseases. The underlying cause of death is defined by the World Health Organization (WHO) as "the disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury." It is a single value assigned to each death based on the details as entered on the death certificate. When more than one cause is listed, the order in which they are listed can affect which cause is coded as the underlying cause. This means that similar events could be coded with different underlying causes of death depending on variations in how they were entered. Consequently, while underlying cause of death provides a convenient comparison between cause of death categories, it may not capture the full impact of each cause of death as it does not always take into account all conditions contributing to the death.

Data and Resources

- [2025-2026 Provisional Deaths by Month by County](#) This data table reports the provisional monthly number of deaths that...
- [2014-2024 Final Deaths by Year by County](#) This data table reports the annual number of deaths that occurred in each...
- [1999-2013 Final Deaths by Year by County](#) This data table reports the annual number of deaths that occurred in each...
- [1979-1998 Final Deaths by Year by County](#) This data table reports the annual number of deaths that occurred in each...
- [1970-1978 Final Deaths by Year by County](#) This data table reports the annual number of deaths that occurred in each...

Download all

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# Geographic Service Area-Calculating Un-met Needs

Add Filter

Show 25 entries:

Hide/Unhide Columns

Showing 1 to 11 of 11 entries (filtered from 232,232 total entries)

Search:

_id	Year	County	Geography_Type	Strata	Strata_Name	Cause	Cause_Desc	ICD_Revision	Count	Annotation_Code	Annotation_Desc	Data_Revision_Dat
		monterey	Residence	Total Population		CAN						
78664	2017	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	596			03/19/2026
99776	2018	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	553			03/19/2026
120888	2019	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	536			03/19/2026
142000	2020	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	550			03/19/2026
163112	2021	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	605			03/19/2026
184224	2022	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	586			03/19/2026
205336	2023	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	563			03/19/2026
226448	2024	Monterey	Residence	Total Population	Total Population	CAN	Malignant neoplasms	ICD-10	569			03/19/2026

death-profiles-by-county—2014-2024 Final Deaths by Year by County

Sort: \_id

< 1 >



# Geographic Service Area-Calculating Un-met Needs

## Now, Lets do some math:

1. Add up all the CANCER Deaths divided by Years assessed = **Average # CANCER Deaths per year**
2. **Average # CANCER Deaths per year x 0.7 = # of patient with Terminal illness “not Cancer”**
3. **Average # CANCER Deaths per year + # of patient with Terminal illness “not Cancer” = Avg. # of deaths in the county/year**
4. **Avg. # of deaths in the county/year x 0.5 = “potential Hospice Patients by county”**

## **Example:**

1. Count Total = 6267 Cancer Deaths per year, across 11 years = **569.7 Avg. Cancer Deaths/year**
2. **569.7 x 0.7 = 398.8 Non-Cancer Deaths**
3. **569.7 + 398.8 = 968.5 Avg. # of deaths in the county/year**
4. **968.5 x 0.5 = 484.25 Potential Hospice Patients Per year**



# Geographic Service Area-Calculating Un-met Needs- “# of patients Other Hospice Providers can “accommodate

## Method and Data Source:

### Calculating “# of patients Other Hospice Providers can “accommodate”

1. CDPH, CA Health Facilities information database “Cal Health find” via the “Find and compare a Health Care Facility”
2. Find all the Hospice’s listed in your “parent” county, and Filter the columns as indicated below.....
3. **Facility Name** = Blank
4. **Location** = Primary “parent” county
5. **Facility Type** = Hospice
6. **Types of Care and Services** = “All Care & Services”



# Geographic Service Area-Calculating Un-met Needs- “# of patients Other Hospice Providers can “accommodate”.

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Home.aspx

VNA Intranet - Ho... Login | ADP Elsevier NHPCO CMS Quarterly Q&... Clarity SHP VNA Intranet - Ho... McBee OKTA Sage Intacct MyUnity Ticket Nancy Peta Files Fazzi HHCAHPS

en Español Contact Us About News & Media Jobs/Careers Select Language + Text Resize

**CDPH**  
California Department of Public Health

I am looking for I am a Programs A-Z Index

Home | Health Facilities | California Health Facilities Information Database | Home

## Cal Health Find Database

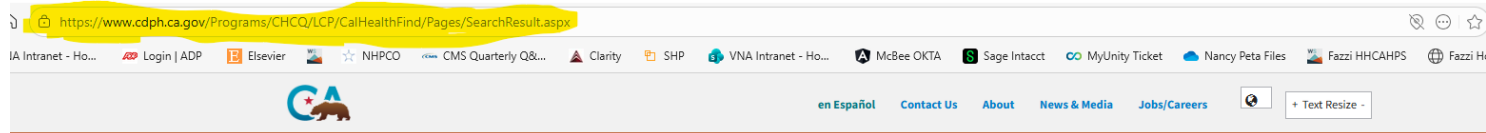
Looking for a health facility? Filing a complaint? Click below.

**FIND AND COMPARE A HEALTH CARE FACILITY**

**FILE A COMPLAINT**



# Geographic Service Area-Calculating Un-met Needs- “# of patients Other Hospice Providers can “accommodate”.



I am looking for

I am a

Programs

A-Z Index

Home | Programs | Center for Health Care Quality | Licensing and Certification Program | CalHealthFind | Search Result

## CAL HEALTH FIND DATABASE

Facility Name:  Location:  Facility Types:  Types of Care & Services:

- Select all
- Hospice
- Hospice Facility

The information displayed in Cal Health Find comes from data received from the Automated Survey Processing Environment (ASPEN) system and the state Electronic Licensing Management System (ELMS). While the Center for Health Care Quality (CHCQ) strives to ensure its accuracy, CHCQ presents the data as it is recorded in ASPEN and ELMS. Data not maintained by the Center for Health Care Quality's Licensing and Certification Program is not available on Cal Health Find.

Due to suspension of routine inspections and to visitation restrictions imposed during the COVID-19 pandemic, complaint, deficiency, and enforcement action data in 2020 and 2021 may appear to be trending downward when compared to prior years. Consequently, Cal Health Find data on performance histories may not reflect actual conditions in facilities during those years. The public should take this information into account when considering facilities.

If you experience disability access issues, please contact [CalHealthFind@cdph.ca.gov](mailto:CalHealthFind@cdph.ca.gov). For additional information on CDPH's compliance with the Americans with Disabilities Act (ADA), visit the [CDPH Web Content Accessibility page](#). For more information on CDPH's privacy policy, visit the [CDPH Privacy Policy page](#).



# Geographic Service Area-Calculating Un-met Needs- “# of patients Other Hospice Providers can “accommodate”.

## Now, Lets do some math:

1. Total Number of Licensed Hospices in the county x 56 = Avg. # patients that all hospice facilities can accommodate.

## Example:

33 Hospice Facilities in Monterey County x 56 = 1848 Avg. # of patients that ALL hospice facilities can accommodate.

## Bringing it all together:

Next Compare the “Potential Hospice Patients Per year” vs. “Avg. # of patients that ALL hospice facilities can accommodate” to determine un-met need.

## Un-Met Need Analysis:

484.25 Potential Hospice Patients Per year vs. 1848 Avg. # of patients that ALL hospice facilities can accommodate.

## Outcome: “Un-Met Need”-Standard Not Met for Monterey County

Note: Calculations need to be made for reach county that a Hospice agency wishes to serve.



# Geographic Service Area-Policy and Procedure

Take Home Suggestion: Create a "Timely Care Policy" outlining the below components

- **Geographic Service area Determination (section 74820)**
  - Required for:
    - Initial Licensee application
    - For CHOW
    - Expansion
  - Time trials Procedures
- **Response Time Policy Procedures & Monitoring “Night on call” and day/evening (Section 74848)**
  - Procedures to provide support until visit occurs
  - On-call Procedures to ensure a RN can appear in person within 2 hours
  - On-call procedures for how personnel must contact management (MD Director + DPCS, etc.)
- **Staffing Ratio Volume & Monitoring (Section 74848)**
  - Patient acuity System





# Section: 74824 Change of Ownership (CHOW )

May only apply for CHOW after 5 years from date of initial license.

- Major change in ownership interest
  - Transfer of beneficial interest (one or multiple transactions)
  - Results in 50% or more ownership
- Nonprofit corporation – Transactions in Corporations Code section 5914
- Change in Partnership
- Merger of corporations

- Sale, transfer or dispose of title and property or loss of right to occupy building
- All of hospice property and assets are leased to another entity
- Timeframe
  - A complete CHOW application & licensing fees to CDPH 120 days prior to anticipated change.
  - CHOW not effective until approved by CDPH.
- Within the five-years:
  - Emergency conditions
  - Limited Resources and capacity
  - Financial Hardship



# Section 74828: Reporting Changes Important Dates

Application to CDPH:

- 120 days prior for changes in:
  - Geographic service area
  - Indirect ownership
  - Transfer of beneficial ownership interest of 5% or more (but less than 50%)
- 60 days prior to change in:
  - Location
  - Addition or deletion of service
  - Suspension of optional services (PT,OT,ST)
  - Lease termination
  - Infrastructure damage



# Section 74828: Reporting Changes Important Dates

- **10 business days for changes in\_**
  - Administrator or designee
  - Director of Patient Care Services or Designee
  - Medical Director or designee
  - Hospice's Medicare or Medi-cal certification status (including enrollment )
  - Change in hospice governing body or principal officers (CMS 855 as well)
  - Name of hospice, licensee, mailing address, National Provider identifier, property owner of hospice or multiple locations



# Section: 74832 Denials of Applications

- Application for license denials for:
  - Failure to comply with:
    - Health and Safety Code Division 2, Chapter 8.5
    - Title 22 of California Code of Regulations, Division 5, Chapter 6.5
    - Title 42 of the Code of Federal Regulations, Chapter 4, Subchapter B, Part 418, if applicable (Medicare)
  - Failure to implement all plans of correction to deficiencies
  - Has had a hospice license involuntary suspended or revoked in the past 24 months
  - Incomplete application and failure to remediate all discrepancies
  - Incomplete evidence of unmet need
  - Liable for unpaid licensing fees
  - Does not hold active status with CA Secretary of State, the Franchise Tax Board or both
  - Inaccurate information provided
  - Hospice management personnel professional license indicate disciplinary actions within 7 years prior to application and applicant does not replace personnel (fraudulent billing, billing services not performed, incorrect billing code or upcoding, altering dates of service, double billing or excessive billing, forgery of a document, creating or altering a fictitious document, submitting falsified academic record, use of fabricated address of service location, improper determination of eligibility of hospice care
  - Record of felony conviction, violation of patient data (HIPAA, CMIA, IPA), abuse or negligent conduct towards patients, inadequate care or immediate jeopardy.
- Must submit written petition to the CDPH within 15 days after receipt of notice



# Section: 74836 Renewals and Expirations

- License expire 24 months from effective date
- CDPH send renewal notice 45 days prior to expiration
  - **IF YOU DO NOT RECEIVE IT AT 45 DAYS CONTACT CDPH BEFORE LICENSE EXPIRES**
- Submit renewal application at least 30 days prior to expiration
  - Review and validate all information
    - Contacts (general and emergency)
    - Name, phone, email, fax and alternate
  - Pay all license fees
  - The person signing the renewal application must be the owner, CEO or Administrator.



# Section 74840 Voluntary Cancellation



Notify CDPH in writing at least 60 days prior to anticipated date

Closure of hospice  
Closure of a multiple location



Closing notification must be sent to:

Center for Medicare and Medicaid Services (if Medicare certified)  
Hospice Accreditation organization (if applicable)



Discharge statement to CDPH for existing patients prior to anticipated closure.

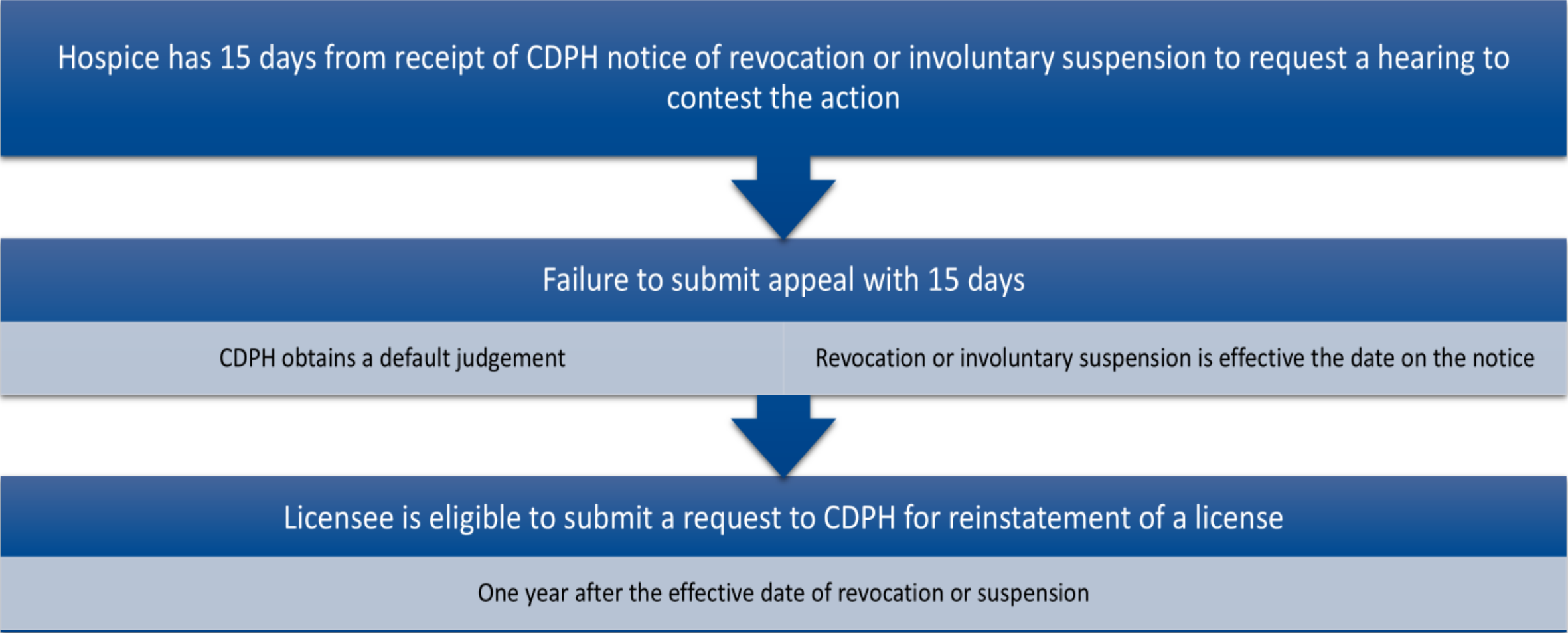


# Section: 74840 Involuntary Suspension, Revocation, Termination

- Suspension or Revocation for:
  - Failure to comply with regulations
  - Failure to implement all plans of correction for deficiencies
  - Failure to pay license fees and late payment penalties
  - Operating with expired license
  - Providing inaccurate information on application and any documents submitted to CDPH



# Section 74844 Involuntary License Suspension, Revocation and Reinstatement



# LET'S FOCUS ON REQUIREMENTS OF SECTION 74848



# Section: 74848: Nursing

- Staffing Ratio

- RN or LVN Services required 24/7

- RN or LVN must be assigned 12 or fewer patients. Assigned Means “primary responsibility for the

provisions of care within their scope of practice”

- “Except where RN’s are required to provide care pursuant to their scope of practice”.

- LVNs can be tasked with day-to-day nursing care on behalf of the RN

- ONLY Agency employed or contracted staff that are “assigned to provide direct care can be included in the nurse to patient ratio”



# California LVN Scope of Practice (Respiratory) June 6, 2025 REFERENCE

## LVNs CAN perform the following:

- Patient data collection.
- Application and monitoring of a pulse oximeter.
- Medication administration by aerosol that does not require manipulation of an invasive or non-invasive mechanical ventilator.
- Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation.
- Hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites.
- Use of a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency.
- Documentation of care provided, which includes data retrieved from performing a breath count or transcribing data from an invasive or non-invasive ventilator interface.
- Observing and gathering data from chest auscultation.



# California LVN Scope of Practice **REFERENCE**

## **LVNs CANNOT perform the following:**

- Manipulation of an invasive or non-invasive ventilator.
- Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion.
- Pre-treatment or post-treatment assessment.
- Use of medical gas mixtures other than oxygen.
- Preoxygenation or endotracheal or nasal suctioning.
- **HOSPICE ONLY:** Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.
- **HOSPICE ONLY:** Tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.
- *Important Note: The Vocational Nursing Practice Act authorizes LVNs to perform services under the direction of only licensed physicians, registered nurses (including nurse practitioners [NP]) and naturopathic doctors. LVNs work with Respiratory Care Practitioners as part of patient care team members but shall only work under the direction of a licensed physician, registered nurse (including NPs) and naturopathic doctors.*



# Section: 74848: Nursing

- Policy and Procedures required to:
  - Develop policies for on-call staffing and emergency communication
  - Determine staffing for on-call nursing services to ensure that a **RN can appear in person when required.**
  - For how on-call Nursing staff can contact Hospice Management, including but not limited to DPCS, MD Director for after-hours assistance.



# Section: 74848 Nursing

- Patient Acuity System (“PAS”)
  - Must be developed by agencies
  - **Policy and Procedures required**
  - Must include consultation by RN personnel to provide input on the development and implementation of the patient acuity system
  - Methods must be developed for.....
    - To predict nursing care requirements for each individual patient
    - Method to assess and validate the amount of nursing care for each patient
    - Method to Discern trends and patterns of nursing care delivered by staff (i.e. Patient Categories suggested)
    - A method to test the accuracy of the acuity system
    - Method to assess resource allocations based on nursing care requirements for each shift (Suggestion: Night on call Heat maps for call tracking and/or visits?)
    - Method to test the reliability of the patient acuity system (per pt. category)
    - Methods for staff to provide input about the PAS and staffing plan for ongoing suggestions
    - Reliability of the patient acuity system must be reviewed at least annual by a committee appointed by the DPCS.



# Nursing: Section 74848

- **Acuity System Annual evaluation committee**
  - Committee Requirements:
    - Does the Patient Acuity System accurately reflect patient care needs and accurately determine staffing requirements
    - **Half** the committee **MUST** be **RN's** who provide direct patient care
    - Any changes must be resolved and implemented within 30 days
    - Meeting Minutes must be taken and maintained and they **MUST** Contain
      - Meeting agenda
      - Suggested adjustments.....
      - Implemented changes.....
      - Personnel and titles who participated
      - Name and contact information of the DPCS
  - **MUST** be **SIGNED** by the **ADMINISTRATOR**



# Section: 74848 Nursing and Staffing Ratio's

## Patient Acuity System Annual evaluation committee (Sample Agenda)

**Patient Acuity System  
Committee Meeting Minutes**

**Committee Agenda:**

**Personnel Present and titles:** \_\_\_\_\_

**Name and contact information of the DPCS:** \_\_\_\_\_

**Meeting agenda:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Questions to address during PAS Review:**

1. Does the PAS accurately reflect patient care needs and accurately determine staffing requirements?
2. Review our Method to test the accuracy of our Patient acuity system? Does it work to predict staffing levels?

**Suggested adjustments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** *Any changes must be resolved and implemented within 30 days*

**Implemented changes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Administrator Name:** \_\_\_\_\_

**Administrator Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_



# HOSPICE MANAGEMENT SECTIONS



# Section: 74875 Administrator

- **Qualifications**
  - Baccalaureate degree or higher in a health-related field
  - Minimum of two years full-time supervisory or managerial experience in a hospice, home health agency, primary care clinic, or health facility within the last five years.
  - No disciplinary action taken within the last seven years
- **Appointed by Governing Body in writing**
- Must be on premises of the hospice or accessible by telecommunications during scheduled work hours
- **Multiple employers**
  - Can only be concurrently employed by no more than two hospices as long as both are located in the same rural area.
- **Vacancy**
  - Filled within 60 days
  - Unable to fill submit an extension request to CDPH
  - Notify CDPD of the replacement within 10 days



# Section: 74875 Administrator

## Administrator Designee

- Meets the requirements of Administrator
- Appointed by Administrator In writing
- Same criteria for Administrator
  - Disciplinary action
  - Concurrent employment
  - Vacancy and extension requirements
  - Notification of CDPH of appointment



# Section: 74852 Director of Patient Care Services



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## Qualifications:

- Registered nurse
- Baccalaureate or higher degree in nursing or other health related field
- Minimum of two years of full-time supervisory or managerial experience in hospice or home health within last five years

**OR**

- Registered Nurse
- Minimum of four years of full-time supervisory or managerial experience in hospice or home health within last five years

**No disciplinary action in the last seven years**  
**Appointed by the Administrator**



# Section: 74852 Director of Patient Care Services



## Concurrent Employers

No concurrent employers

Except

**Must be in the same rural area**

No more than two hospices



## Vacancy

Must be filled in 60 days from vacancy date

If unable to fill submit request for extension to CDPH (job advertisements, job description, evidence of competitive pay, no diminished quality of patient care)

Must notify the CDPH of replacement within 10 business days of appointment (Change of Director of Patient Care Services)



# Section: 74852 Director of Patient Care Services

## Director of Patient Care Designee

- Meets the requirements of DPCS
- Appointed by Administrator In writing
- Same criteria for:
  - Disciplinary action
  - Concurrent employment
  - Vacancy and extension requirements
  - Notification of CDPH of appointment



# Section:74856 Medical Director

## Qualifications:

- Current & valid license
- Minimum of two years of full-time supervisory or managerial experience in a hospice, home health or providing palliative care to patients in the last five years
- No disciplinary action within the last seven years

Appointed by the governing body

Employed by or under contract (full-time or part-time)



# Section: 74856 Medical Director



## Concurrent Employers

**Must be in the same rural area**

No more than three hospices



## Vacancy

Must be filled in 60 days from vacancy date

If unable to fill submit request for extension to CDPH (job advertisements, job description, evidence of competitive pay, no diminished quality of patient care)

Must notify the CDPH of replacement within 10 business days of appointment (Change of Medical Director)



# Section: 74856 Medical Director

## Medical Director Designee

- Meets the requirements of Medical Director
- Appointed by Administrator In writing
- Employed or Contracted
- Same criteria for:
  - Disciplinary action
  - Concurrent employment
  - Vacancy and extension requirements
  - Notification of CDPH of appointment



- What are the education requirements for:
  - Administrator
  - Director of Patient Care Services
- Years of experience for:
  - Administrator
  - Director of Patient Care Services
  - Medical Director
- How many concurrent Hospices can they work for:
  - Administrator
  - Director of Patient Care services
  - Medical Director
- Where must the concurrent Hospices be located?

A  
time  
to  
Remember

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# Section: 74860 Admission

- A hospice must:
  - Develop, implement & maintain Policies & procedures for the admission of hospice patients
  - Admit only with a physician's order
  - Accept & retain patients only where the hospice can provide care
- To be admitted a patient must have:
  - Informed consent ([patient's or representative or both])
  - A need for hospice care & terminal diagnosis
  - A need for preliminary hospice care (palliative care consultations, counseling and POC, bereavement & grief services)
  - Permanently reside in hospice's approved geographic services area
- Certification of terminal illness



# Section: 74860 Admission

- Certification of Terminal illness
  - Initial CTI from Medical Director or Designee in consultation with attending physician
  - A physician member of the IDT may certify patient's terminal illness if patient does not have an attending or is unavailable
  - Signed and filed in medical record
- Initial CTI signed and dated by:
  - Medical Director or Designee
  - Attending Physician or hospice physician who performed the certification (not included in COP)



# Section: 74860 Admission

- Medical Director or designee must include the following documentation in the initial CTI:
  - Attestation of patient's prognosis includes a life expectancy of 12 months or less if terminal illness runs natural course
- Brief narrative explaining clinical findings supporting 12-month prognosis
  - Narrative must include:
    - Information on patients' individual clinical circumstances (no check boxes)
    - Clinical information supporting medical prognosis
    - Attestation statement above signature confirming composing the narrative based on
      - the patient's medical record or
      - physician's personal examination of the patient
      - Or both
  - Must be located immediately prior to the Medical Director or Designee's signature



# Section: 74860 Admission

- Addendum to narrative of initial CTI added after signed
  - Must be signed by the Medical Director or Designee immediately following the added narrative
- Before certifying the terminal illness, the physicians must consider:
  - Diagnosis
  - Other diagnosis related or unrelated to terminal illness
  - Current clinically relevant information supporting all diagnosis
  - Current medications and treatments
  - Medical management of conditions unrelated to terminal illness



# Section: 74860 Admission

- At time of admission hospice must :
    - Complete initial assessment of immediate needs
    - Provide written materials, in the primary language of patient or representative explaining:
      - Hospice’s policies relating to advanced directives
      - Information regarding advanced directives
      - Patient’s rights to make decisions concerning medical care including :
        - Right to accept or refuse treatment
        - Right to create advanced directive
      - Hospice’s policies regarding implementing advanced directives
    - Include in medical record
      - A copy of advanced directive prepared & signed by patient or representation
- OR
- A document signed by patients or representative acknowledging they do not have advanced directive at time of admission and we re provided information by the hospice



# Section: 47864 Assessments

- **RN must complete initial assessment of patient and family within 48 hours of the patient's admission**
  - Must be in the location where the patient receives hospice care
  - Basis for development of Plan of Care
  - Document findings and filed in medical record
- **All members of the interdisciplinary team must complete comprehensive assessment within five days of the admission to hospice**
  - "in collaboration with the patient's attending physician" if not available
    - Medical director
    - Another hospice physician



# Section 74864: Assessment

- Comprehensive Assessment must identify and evaluate
  - Patients' needs regarding terminal illness and related conditions
  - Must consider the following:
    - Nature of condition that caused admission to hospice including objective data and self-reported symptoms and experiences
    - Potential complications and risk factors affecting hospice's ability to address patient needs through Plan of Care
    - Physical condition
      - Functional status & abilities
      - Mental status & ability to understand & participate in own care
      - Symptoms & severity of pain, level of discomfort & symptom relief
      - Medications including over the counter
      - Bereavement assessment (social, spiritual & cultural factors that may impact patient's family's ability to cope with death)
      - Spiritual orientation & needs
      - Caregiver & family's willingness and capacity to care for patient
      - Need for referrals to other health care professionals



# Section: 74864 Assessments

- Develop, implement, and maintain documented policies and procedures to:
  - Include data elements that allow measurement of patient outcomes in a comprehensive assessment
    - Be measured & documented in the same way for all patients
    - Consider aspects of care related to hospice
- Review, revise and update comprehensive assessment
  - In collaboration with attending physician, Medical director or hospice physician
  - As frequently as the patient's condition requires, but not less than every 15 days
- Assessment to include:
  - Evaluation of changes since last assessment
  - Evaluation of patient's progress toward outcomes in POC
  - Patient's response to care provided
- Documented in writing and filed in patient medical record



# Section: 74868 Plan of Care (POC) & Review

- **Assigned interdisciplinary team who:**

- Provides all services according to POC
- **Collaborates with physicians**
- Work together to meet physical, medical, psychosocial, emotional & spiritual needs of patient and family bereavement experience
- Members are appropriately trained and credentialed in respective field of expertise
- Jointly responsible for the provision of care
- Develop a written POC based on comprehensive assessment of patient needs (Hospice must guarantee)

- **Hospice must assign at least one RN to each interdisciplinary team to:**

- Implement POC
- Coordinate care
- Coordinate & implement periodic comprehensive assessments

- **Plan of Care**

- Current Diagnosis
- Goals and outcomes
- Types and frequency of services provided
- **Identification of RN and assigned interdisciplinary team members**
- Family and caregivers who provide care
- Patient symptoms
- Pain management
- Ability of caregiver to safely administer medications & IDG support
- Medical Supplies & equipment (MUST be provided by hospice)
- Orders for treatments & frequency provided by IDG
- Patient's physical, cognitive, and functional limitations
- Physical activities
- Special dietary needs
- Food and Drug allergies
- Palliative care needs
- Safety measures
- Documentation of education, training and written instructions provided regarding:
  - Responsibilities of care & services in POC
  - Assessment of caregiver's ability to provide care in POC
  - Management & safe disposal of controlled substances in patient's home
  - Bereavement needs of family
  - Anticipated discharge date, if applicable



# Section: 74868 Plan of Care (POC)

- Develop, implement & maintain communication system policies & procedures to:
    - IDT utilizes a documented system of communication
    - IDT system must share information
    - In all setting with direct or under arrangement care providers
    - With any other non-hospice health care providers providing non-hospice services to the patient
  - RN assigned to IDT must direct, coordinate and supervise care & services provided by all hospice and non-hospice care providers
  - Patient's individualized POC is develop by IDT and approved and signed by attending, Medical director of Hospice physician
  - IDT may propose modifications but may only be implemented after attending physician, Medical Director or Hospice physician approve in writing
- **Must develop, implement & maintain policies and procedures identifying all significant changes that must be reported**
    - Hospice personnel or **volunteer notifies the physician if they observe a significant change to patient's condition** indicating changes to POC are needed
  - Significant changes
    - Loss of coherency or cognitive abilities
    - Decrease in weight or appetite
    - Onset of behavioral conduct issues
    - Increase in pain
  - List of any other individuals who must be notified of change in condition (i.e IDT)
  - **Methods of notification**
  - **Timeline for notification of care team and patient's representative**



# Section: 74872 Plan of Care Review

- Updated as frequently as the condition of the patient changes but not less frequently than every 15 days
- Interdisciplinary team must discuss & explain in writing:
  - Information from most recent comprehensive assessment
  - Patient's progress toward desired outcomes
  - Reassessment of response to care
- All updates documented & made in collaboration with patient's physician, Medical Director, or Hospice physician
- All versions of POC must be filed in Medical record



# Hospice Management Orientation & Annual training

## Details in Next Section



## Section: 74884 Personnel Records:

- Must be maintained for 4 years following Termination/Separation
- Hours and Dates worked must be maintained for 12 months.
- Records maintained in confidential manner
- Records must be made available within 24 hours upon request by CDPH



# Section: 74884 Personnel Records

- Personnel Records MUST CONTAIN:

- (1) Full legal name.
- (2) Social Security number.
- (3) Home address.
- (4) Mailing address, if different than home address.
- (5) Phone number.
- (6) A copy of the individual's professional license, including license number and date of expiration, if applicable.
- (7) Job title and employment classification, including, but not limited to, a statement of duties performed by the individual .
- (8) A resume containing the individual's qualifications for the position.
- (9) Verification of employment history and experience, including, but not limited to, reference checks performed by the hospice.
- (10) Start date of employment.
- (11) Documentation of completion of hospice management personnel orientation and training requirements pursuant to section 74 880, if applicable.
- (12) **Written confidentiality agreements between the hospice and the individual.** Agreements must be in accordance with the hospice's policies and procedures and must be signed and dated by the individual and the hospice Administrator.
- (13) **Proof of clearance from the Office of Inspector General's List of Excluded Individuals and Entities.** The hospice must complete the proof of clearance prior to the individual's employment.
- (14) **Signed and dated conflict of interest forms,** including, but not limited to, the initial conflict of interest form required at time of hire, and all subsequently required forms during employment.
- (15) All performance evaluations completed during employment with the hospice.
- (16) Date of separation from the hospice, if applicable.

NOTE: FEDERAL REG"s- I9 form must be kept by HR and must be signed within 3 days for ICE enforcement. I9 and Health records; KEEP IN A SEPARATE FILE.



# Section 74888: Medical Record Service

- A hospice must provide a patient a copy of their medical record within 15 days after receiving a release of medical information request
- Request must be documented in medical record
- Policy and Procedures are required for “Information Governance”
  - Governing Body must approve of the policy
    - “Information Governance” policy **Content Requirements:**
      - (1) The retrieval of medical information.
      - (2) Reconciliation. “reconciliation” means the process of ensuring that a hospice generates a complete and accurate medical record for a patient upon discharge.
      - 3) Deficiency analysis. “deficiency analysis” means the process for detecting absent or missing medical information in a patient’s medical record.
      - (4) Coding
      - (5) Filing
      - (6) Indexing
      - (7) Quality and content control
      - (8) Release of information



# Medical Record Service: Section 74888

- **Policy and/or Procedures for Appeals to Amend Medical records:**
  - How and when the hospice must provide notification to a patient if a request for correction or amendment to a patient's medical record was received.
  - How to determine if a patient's request to correct or amend their medical record should be approved or denied.
  - How and when the hospice must provide notification if a request for correction or amendment to a patient's medical record was approved or denied.

**Note:** Documentation showing that a patient made a request, and whether the request was approved or denied, must be included in the patient's medical record. If a request was denied by the hospice, documentation must include a written justification for denial.



# Section 74892: Medical Record Content

WORK WITH YOUR EMR or Intake Team to ensure you have the below items

MUST INCLUDE: (Not all inclusive)

- Patients Social Security number OR Individual taxpayer ID AND (1) other Identifier.
- The patient's biological sex assigned at birth.
- The patient's **gender identity**, if identified by the patient or the patient's representative.
- The patient's **sexual orientation**, if identified by the patient or the patient's representative.
- The patient's marital or registered domestic partner status.
- The patient's representative to be notified in case of emergency or death, as identified in writing by the patient or the patient's representative
- A copy of the written notice provided to the patient or the patient's representative in the patient's primary language regarding advance directives pursuant to section 74860(e)(2) and (e)(3)(B), if applicable. If the patient executes and provides advance directives at any time while receiving hospice services, a copy must be retained in the patient's medical record.
- The medical record must include identification of all individuals who helped develop each plan of care
- Complete and accurate **clinical notes** dictated or **written on the day of service by the personnel providing the service.**
- Documentation recording **notifications of a significant change in the patient's condition to all required individuals**
- Documentation regarding **written instructions** to the patient and family **on the use, management, and disposal of controlled substances and durable medical equipment and supplies.**
  - *Documentation **must include a signature** made by the recipient acknowledging receipt and comprehension of the instructions provided.*



# Section: 74892 Medical Record Content

- Discharge Summary Requirements:
- If discharged by death, written discharge notes and summary must include, but are not limited to:
  - Date of death
  - Location of death
  - Cause of death
  - Extent to which treatment goals were obtained, including pain and symptom management
  - Degree of emotional support extended to the patient's family, caregivers, or other individuals
  - Bereavement services plan.



# Section: 74892 Medical Record Content

- Discharge Summary Requirements:
- Live discharge or transfer notes and a summary which must include, but is not limited to:
  - Date of and reason for termination of service
  - Summary of the patient's physical, mental, spiritual, and emotional status at the time of discharge.
  - Method of initiation of discharge or transfer, whether by physician, hospice, patient, patient's representative, patient's family, or any such combination.
  - A written physician's discharge order from the hospice Medical Director
  - Documentation of notification of the termination of services to the patient, the patient's representative or family, and the patient's attending physician, as applicable. If an attending physician is involved in the patient's care, the attending physician must be consulted prior to discharge and the attending physician's review and decision must be included in the discharge summary.
  - Extent to which treatment goals were obtained.
  - Referrals made, if applicable.
  - If the patient is transferring to another hospice, copies of consent for care, all certifications of terminal illness, the patient's plan of care, and other information as requested by the receiving hospice must be included



# Section 74896 and 74900: Medical Record Use and Access

- Medical Records must be maintained for 10 years. Age 18 +1 year for patients under 21 or 10 years at a minimum.
- Destruction of Records requires a certificate of destruction from a shredding company that is HIPPA compliant
- Records destroyed prior to the new 10 years Requirement to be retained must be reported to the state within 24 hours.
- A hospice must submit a written request to, and obtain approval from, the Department to store hard copy patient medical records at an off-site storage facility
- The hospice must have a signed statement on file verifying an authorized hospice personnel's sole authorship to document in a patient's electronic health record under a unique identifier
- Develop, implement, and maintain a documented disaster recovery policy and procedure for manual clinical documentation if the electronic health record system becomes non-functional
  - Perform regular backups no less than every 24 hours to ensure personnel have access to current and accurate information at all times.
- Hospices that use an electronic health record system must request and receive approval from the Department to store a physical server off the hospice's premises



# Section 74896 and 74900: Medical Record Use and Access

- A hospice must develop, implement, and maintain documented policies and procedures that address:
- (1) The content of patient medical records, pursuant to section 74892.
- (2) The timeliness of entries, corrections, and additions made to patient medical records. (**Complete and accurate clinical notes dictated or written on the day of service**)
- (3) The maintenance, security, and storage of patient medical records.
- (4) Patient medical record retention, pursuant to subdivision (b).
- (5) Which hospice personnel are authorized to access and to document in patient medical records.
- (6) The creation of a unique identifier to guarantee that only authorized hospice personnel can document in patient medical records after authenticating their identity.
- (7) The use of countersignatures or dual signatures which must include:
  - (A) The authorized hospice personnels' full legal name.
  - (B) The authorized hospice personnels' medical or professional credentials.
  - (C) The **authorized hospice personnels' unique identifier**, as determined by the hospice's policies and procedures.
  - (D) The date and time of authentication.
- (8) How and when to report a breach or a suspected breach of patient medical record information.



# Section 74896 and 74900: Medical Record Use and Access

- Changes to Medical records: (Create or review Procedures around Corrections)
  - A hospice must guarantee that entries regarding the provision of care or services provided are not altered without a written explanation of the reason for alteration.
  - Authorized hospice personnel who make a medical record entry error or alter an entry, whether in a hard copy or electronic health record, must:
    - Put a single line through incorrect information, or **use an electronic stamp indicating the entry was an error.**
    - **NOTE: REVIEW Medicare Integrity Chapter to align with “Late Entry” vs. “Amendment” procedures**
- **Change of ownership:** Medical Records storage Statement attestation required. Content contained in Section 74896



# Medical Record- “Homework” items

Review/Update Policies and Procedures for:

- Medical Records Policy and Procedures
  - Medical Records Use/Access (all with HIPPA Compliance)
    - Unique Identifiers
    - Storage
    - EHR authentication
  - Information Governance Process or Procedure (do you have one already?)
    - Appeals/Amendments process
    - Must be approve by governing body



# Section 74908: Hospice Office Space

- Office space must be :
  - Established place of business
  - **Unshared space where Hospice has exclusive possession**
  - Commercial building owned or leased or exclusively subleased by hospice for a **minimum of 12 months**
- Office Space must include:
  - **Permanently attached signage** that:
    - **Identifies the name of the hospice (same as license)**
    - **Posted on exterior AND interior of space**
    - **Posted business hours visible to the public**
  - Access to restroom during business hours
  - Agency License



## Section 74908: Hospice Office Space (cont.)

- Active **business telephone** line for hospice that is answered 24/7
- **Administrative personnel** to meet operational needs
- **Medical equipment & supplies** (patients and personnel ) with secure storage
- **Office equipment & supplies** to meet operational needs
- Secure storage of:
  - Patient medical records (FIRE SAFE)
  - Medications
  - Personnel employment records



Take a break.  
**You deserve it!**



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# Regulatory Changes

California Medi-Cal Requirements



# Medi-Cal Hospice Program

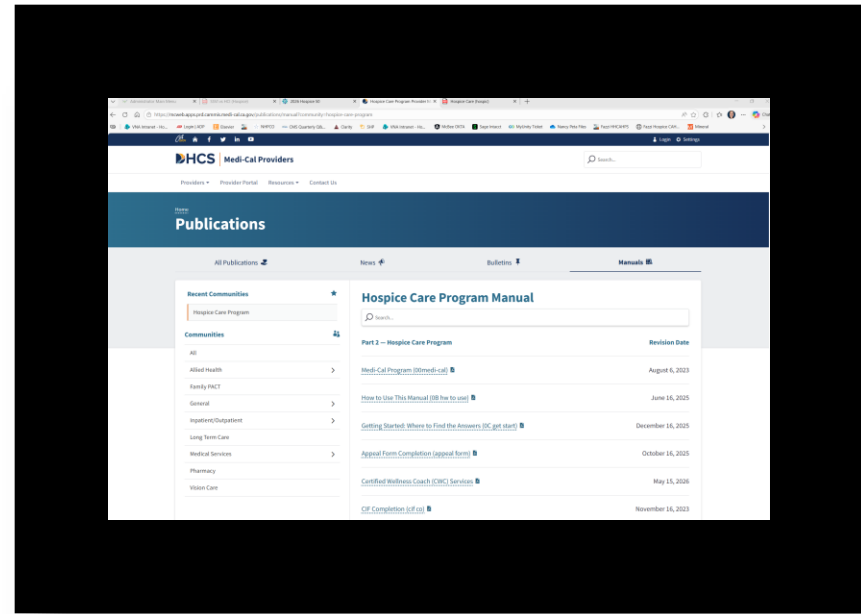
ALL PLAN LETTER "APL" 25-008 & DHCS Regulations

1. Electronic Attestation Form
2. Notice Of Election Form(CDPH Form: 8052)
3. Addendum Form "Patient Notification of Non-Covered Items, Services and Drugs (CDPH Form: 8053)



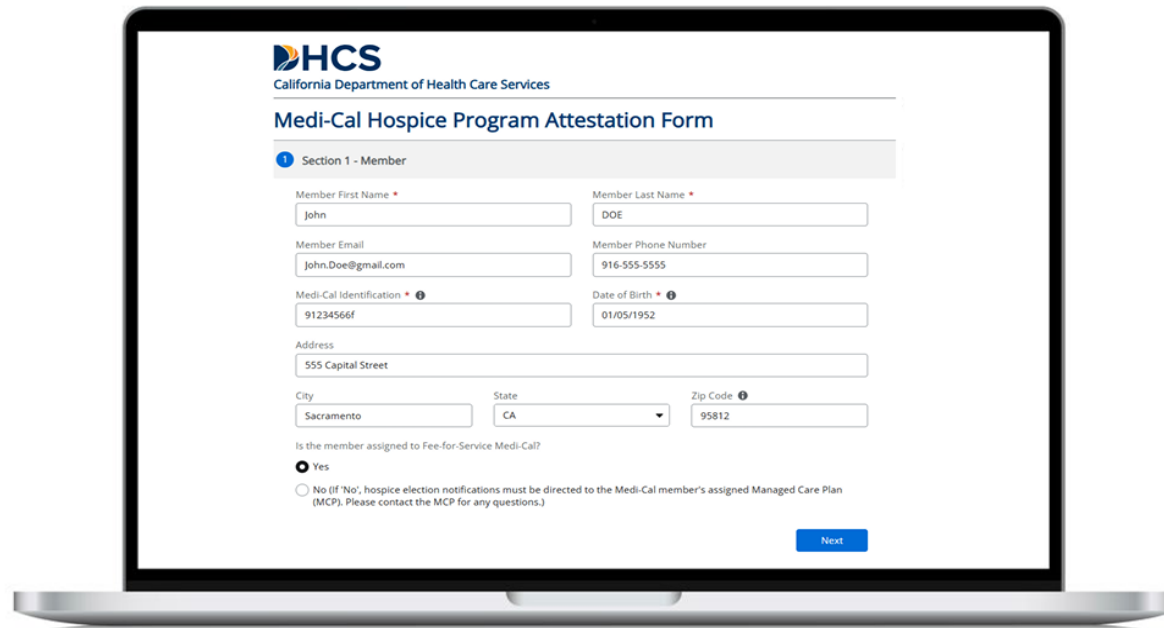
# Department of Health Care Services Resources

- Hospice Care Program Provider Manual | Medi-Cal Providers (DHCS) (April 2026)
  - [www.dhcs.ca.gov/services/medi-cal-resources/hospice-care-hospice-information](http://www.dhcs.ca.gov/services/medi-cal-resources/hospice-care-hospice-information)
- DHCS: APL 25-008 (May 2025)



# Medi-Cal Hospice Program: Attestation Form

## Section 1



The screenshot shows the online Medi-Cal Hospice Program Attestation Form, Section 1 - Member. The form is displayed on a laptop screen. The header includes the HCS logo and the text "California Department of Health Care Services". The title of the form is "Medi-Cal Hospice Program Attestation Form". The section is labeled "Section 1 - Member". The form contains the following fields:

- Member First Name: John
- Member Last Name: DOE
- Member Email: John.Doe@gmail.com
- Member Phone Number: 916-555-5555
- Medi-Cal Identification: 91234566f
- Date of Birth: 01/05/1952
- Address: 555 Capital Street
- City: Sacramento
- State: CA
- Zip Code: 95812

Below the address fields, there is a question: "Is the member assigned to Fee-for-Service Medi-Cal?". The "Yes" radio button is selected. Below this question, there is a note: "No (If 'No', hospice election notifications must be directed to the Medi-Cal member's assigned Managed Care Plan (MCP). Please contact the MCP for any questions.)". A "Next" button is located at the bottom right of the form.

Online Medi-Cal Hospice  
Program Attestation  
Form



# Attestation Form Requirements

- Electronic completion required starting March 2nd 2026
- Must be completed within 5 days of admission to agency
- Penalties for Non-compliance
  - No payment until received by DHCS
  - Required for STRAIGHT Medical (i.e. EDS)
  - Medical Managed Care Program's (i.e. CCAH etc.) may have different requirements
  - Providers should retain DHCS' email confirmation as proof of timely filing.



# Medi-Cal Hospice Program: Notice of Election From (8052)



**Medi-Cal Hospice Program Election Notice**

Email to: [MHospiceClerk@DHCS.CA.GOV](mailto:MHospiceClerk@DHCS.CA.GOV)

Questions, call: (916) 552-9200

<b>Section 1</b>			
Recipient Name:			
Email:	Phone Number:	Medi-Cal ID:	Date of Birth:
Address:	City:	State:	Zip Code:
<b>Section 2</b>			
<b>I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above understand the following:</b>			
I have a terminal illness with a life expectancy of six months or less if the illness were to run its normal course.			Initials:
Hospice care services alleviate pain and suffering and are intended to treat symptoms rather than to cure illness. Recipients younger than 21 years of age may concurrently receive both hospice care and curative treatments of the hospice-related diagnosis. The Medi-Cal Hospice Services and benefits have been explained to me and/or my legal representative. I understand that only recipients younger than 21 years of age may receive both hospice services and curative treatment concurrently.			Initials:
By choosing hospice, I waive my right to payment for all Medi-Cal services, except for: 1) services provided by my elected hospice, 2) services provided by another hospice through an arrangement made by my elected hospice provider, 3) services provided by my attending physician if that physician is not employed by my elected hospice, or receiving any compensation from the hospice for those services. 4) services that are unrelated to my terminal diagnosis.			Initials:
I understand that for recipients ages 21 and over: 1) All my care will be provided by my elected hospice provider for my terminal diagnosis and related conditions. 2) I am not eligible to receive services for my terminal diagnosis and related conditions from providers other than my elected hospice provider or attending physician. 3) I am still eligible for services needed for conditions not related to my terminal diagnosis, and related conditions, such as provider examinations, drugs, or other medical care.			Initials:
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above, understand that I may revoke my hospice election at any time by signing a statement to that effect, and that both I and/or the Legal Representative/Agent and the hospice provider must inform DHCS by submitting the hospice revocation form signed by me. I understand my rights to other Medi-Cal services will resume on that date if I continue to be Medi-Cal eligible. (This revocation is not to be pre-dated or post-dated).			Initials:
I understand that if I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medi-Cal benefits as long as I am eligible for Medi-Cal.			Initials:



I understand that the elected Hospice provider is responsible for any Home Health, Private Duty Nursing, or Personal Care Services, if related to my terminal diagnosis, and related conditions. Medi-Cal benefits will cover care for treatments not related to the terminal diagnosis and related conditions.		Initials:
<b>Section 3</b>		
Admitting Terminal Diagnosis and related conditions ICD-10 Code(s):		
Recipient is currently being admitted from a medical facility.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Facility Name:	NPI Number:	
Recipient is currently being admitted from home.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address:	NPI Number:	
Recipient is transferring from another Home Hospice Agency.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Agency Name:	NPI Number:	
Recipient and/or the Legal Representative/Agent choice of attending physician.		
Attending Physician:	NPI Number:	
<b>I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician. Therefore, the hospice physician is my choice as an attending physician.</b>		Initials:
<b>Section 4</b>		
<b>Services currently being provided to recipient by other Agencies:</b>		
Home Health Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency Name & NPI:
Private Duty Nursing Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency Name & NPI:
Personal Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency Name & NPI:
Elected Hospice Provider Name:	NPI Number:	



<b>Recipient and/or Legal Representative/Agent Statement</b>
I, (Recipient's Name) _____, have read and understand the statements in this document. Recipient Signature: _____ Date: _____
I, (Legal Representative/Agent Name) _____, as the Legal Representative/Agent for (Recipient's Name) _____, have read and understand the statements in this document. Relationship to Recipient: _____ Legal Representative/Agent Signature: _____ Date: _____
<b>Hospice Provider Statement</b>
I, (Hospice Representative Name) _____, Hospice Representative for (Hospice Provider's Name) _____, understand that the Hospice provider is responsible for the coordination of services to ensure that there are no duplication of services. Hospice Representative Title: _____ Signature: _____ Date: _____



# Notice of Election vs Program Attestation

## Key Differences Between the Two Forms

### **DHCS 8052 Form (Notice of Election)**

- Member signs to elect hospice services.
- Provider must keep in the member's medical record.

### **Online Medi-Cal Hospice Program Attestation Form**

- Provider submits to DHCS as official notification.
- Confirms informed consent was obtained using DHCS 8052.
- Required starting March 2026.

DHCS January 2026 Navigating the Updated Online Medi-cal Hospice Attestation Form

[https://www.dhcs.ca.gov/services/medi-cal/Documents/Navigating\\_Hospice-Attestation-Form.pdf](https://www.dhcs.ca.gov/services/medi-cal/Documents/Navigating_Hospice-Attestation-Form.pdf)



# Medi-Cal Hospice Program: Addendum Form (8053)

State of California – Health and Human Services Agency Department of Health Care Services

**Patient Notification of Hospice Non-Covered Items, Services, and Drugs**

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Hospice Agency: \_\_\_\_\_ Date Furnished: \_\_\_\_\_

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services, and drugs):

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Diagnoses Unrelated to Terminal Illness and Related Conditions:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:


Note: The hospice provider makes the decisions whether or not conditions, items, services, and drugs are related to the terminal diagnosis for each beneficiary. This addendum should be shared with other healthcare providers from whom you seek items, services, or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy  
You have the right to appeal the decision of the hospice agency on items not being covered because the hospice provider has determined they are unrelated to the individual's terminal illness and related conditions. If you are enrolled in a managed care plan, you have the right to contact the Managed Care Ombudsman at (888) 452-8609. Email: [MMCDombudsman@dhcs.ca.gov](mailto:MMCDombudsman@dhcs.ca.gov).

Acknowledgement of non-covered items services, and drugs not related to my terminal illness and related conditions.



## Addendum and NOE Form Requirements

- Hospice Agencies Must SUBMIT and ACCEPT form 8052, 8053 within 5 CALENDAR days to the “respective” Medi-cal Managed Plans "MCP" of certification and election to hospice care (i.e. CCAH)
- Hospice Days are “NON-COVERED” if not submitted timely
  - Payment begins after it’s accepted and “patients” cannot be billed for days missed



# Addendum, Attestation & NOE Form Requirements

Agency Required Forms	EDS Payer	CCAH Payer (Primary or Secondary)	Medicare Payer	Medi-Medi starting as EDS	Medi-Medi Starting as CCAH
Hospice Attestation Form	X	-	-	X	-
Hospice Notice of Election Form (8052)	X	X	-	X	X
Hospice "Addendum Form (8053)	X	X	-	X	X
Hospice Notice of Election (Medicare Form)	-	-	X	X	X
Hospice "Addendum Form (Medicare Form)	-	-	X	X	X

## TAKE HOME:

Work directly with your local Medical Managed Care Program's "MCP's on their specific requirements

1. Work with your billing team to figure out where do you send the forms and HOW (fax vs. Email)



# General Medi-Cal Updates in APL 25-008

## As time Permits:

- General In-Patient Care:
  - REQUIRES PRIOR AUTHORIZATION (IN OR OUT-OF NETWORK)
  - Must notify the MCP the next business day if GIP occurs after “normal” business hours
  - Documentation must Include:
    - A written prescription signed by the Member’s attending physician
    - Justification for the general inpatient care level of care
    - A copy of the certification of the Member’s terminal condition
    - A copy of the written initial plan of care
    - A copy of the Member’s signed election form



# General Medi-Cal Updates in APL 25-008

- Face-Face Encounters:
  - NO MORE than 30 days Prior to start of 3<sup>rd</sup> Benefit period
  - For New admits entering 3<sup>rd</sup> Benefit period
    - **Under DOCUMENTED exceptional circumstances, a F2F within 2 CALENDAR days of admission will be considered timely.**
- Transfers:
  - Transfer Summary Required and MUST be SIGNED by MD
    - Content Must include: Diagnosis, Pain and Treatment, Medications, Dietary requirements, Rehab potential, known allergies, and Treatment plan.



# General Medi-Cal Updates in APL 25-008

- Dual Eligible Members (Medi-Medi)
  - DHCS Forms 8052 and 8053 remain required (ROOM and BOARD). (i.e. Same rules apply as if the MCP were Primary payer type!)
  - Room and Board DOES NOT require Prior AUTH
  - MCP's CANNOT require a copy of EOB, Remittance Advice or Denial letter form Medicare to accompany room and board claims
- **Concurrent Hospice and Curative Care for Children:**
  - Under 21 y.o.- May Elect Concurrent Curative treatment for Terminal illness



# General Medi-Cal Updates in APL 25-008

- Reimbursement Codes:
- NOTE: *If the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's 60-day window, paid at the routine home care high rate upon the new admission. If Discharged and RE-admitted in under 60 days then billing days stay in line with previous episode.*
  - Routine home care (service intensity add-on, last 7 days of life) Revenue Code 0552
  - Routine home care (high rate, day 0-60), Revenue Code 0650
  - Continuous home care, Revenue Code 0652
  - Inpatient respite care, Revenue Code 0655
  - General inpatient care (no respite)/hospice general care, Revenue Code 0656
  - Physician services, Revenue Code 0657
  - Routine home care (low rate, day 61+), Revenue Code 0659



## General Medi-Cal Updates in APL 25-008

- Discharge/Death:

- Hospice providers must inform DHCS in writing by submitting notice of the discharge.

- This written notice should be emailed to the DHCS Hospice Clerk at MCHospiceClerk@dhcs.ca.gov.



# General Medi-Cal Updates in APL 25-008

- Revocations

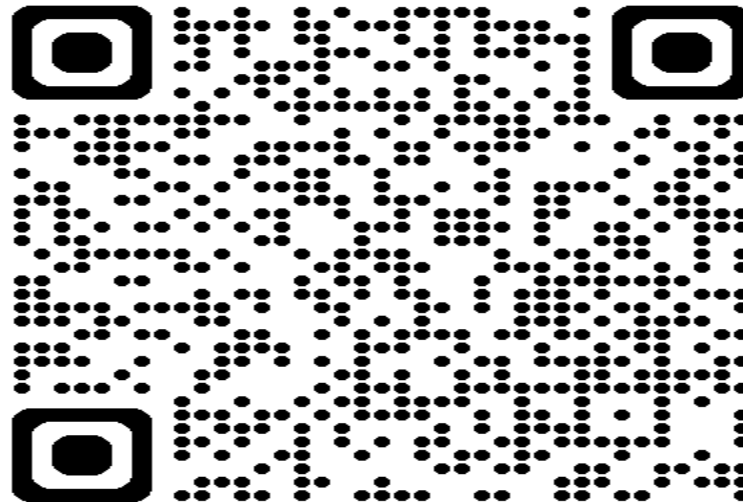
- Hospice providers must inform DHCS in writing by submitting notice of the hospice revocation using the DHCS 8052 form.
- This written notice should be emailed to the DHCS Hospice Clerk at MCHospiceClerk@dhcs.ca.gov.



# Medicare Conditions of Participation Proposed Changes 2026-2027

CMS "Federal" Final Rule expected AUGUST 2026

Federal Register/Vol 91, No. 65/Monday,  
April 8, 2026 Proposed Rule Pg 17338



# CMS FY 2027 Hospice Proposed Rule April 6, 2026

- **Key Payment & Cap Changes**

- **Payment update:** 2.4% increase in hospice payment rates for FY 2027, estimated to add about **\$785 million** in payments compared to FY 2026
- **Cap amount:** Proposed FY 2027 aggregate cap is **\$36,210.11**
- **Rural vs. urban:** Rural hospices would see a slightly larger average increase (3.0%) than urban (2.3%)
- **Non-quality-data hospices:** Those not meeting Hospice Quality Reporting Program (HQRP) requirements would see a **-1.6%** payment adjustment (2.4% update minus 4 percentage points)



# CMS FY 2027 Hospice Proposed Rule April 6, 2026

- **New Transparency & Oversight Measures**
- **Service and Spending Variation Index (SSVI):** Nine claims-based measures tracking hospice utilization and **non-hospice spending** during hospice enrollment. Higher scores signal potential program-integrity risks, possibly leading to audits or enforcement
- **Mandatory hospice election addendum:** Required for all Medicare beneficiaries at the time of hospice election, not just upon request
- **HQRP reporting icon:** Medicare.gov Compare Tool will display an icon for hospices failing HOPE reporting requirements



# CMS FY 2027 Hospice Proposed Rule April 6, 2026

- **Regulatory & Policy Changes**
- **Discharge authority:** Allows a physician designee and the physician member of the interdisciplinary group, in addition to the medical director, to discharge a patient from hospice
- **Telehealth face-to-face policy:** Updated in line with the Consolidated Appropriations Act, 2026 **(Current national moratorium allows for utilization)**
- **Requests for information:** On enhancing community palliative care, building a hospice-specific wage index using BLS data, and the overlap between hospice and “medical aid in dying”



# MAID: Medical Aide In Dying

## Requests for Information:

- What information do hospice providers give to these patients and how often is there overlap when a patient pursues MAID? In other words,
- Do hospices generally continue to provide clinical care while a patient seeks qualification for MAID
- Do patients generally remain on service until death?
- Do hospices encourage patients to revoke their election if they choose to utilize MAID?
- Is there confusion amongst hospices regarding visits or other comfort measures that can be provided during this process, especially on the day of death?
- Do hospices have written policies regarding caring for patients using MAID?
- We are especially interested in understanding what hospices do with any unused lethal medications prescribed for MAID



# Certification of Terminal Illness

## §418.22 Certification of terminal illness.

- During a Public Health Emergency, or through December 31, 2027, whichever is later
- If the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via telecommunications technology and is considered an administrative expense.
  - Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.
- For face-to-face encounters occurring on or after January 1, 2027, hospices must report any such encounters occurring via telecommunications technology on the claim, in accordance with guidance issued by CMS.
- **Beginning January 31, 2026, telehealth may not be used for the face-to-face recertification encounter if any of the following conditions apply:**
  - The hospice patient is located in an area subject to a hospice enrollment moratorium under section 1866(j)(7) of the Act; **(national moratorium waives this)**
  - The patient is receiving care from a hospice provider that is subject to enhanced oversight pursuant to section 1866(j)(3) of the Act;
  - The face-to-face encounter is conducted by a hospice physician or nurse practitioner who is not enrolled in Medicare under section 1866(j) and is not an opt-out physician or practitioner (as defined in section 1802(b)(6)(D) of the act



# Election of Hospice Care

- §418.24 Election of hospice care. (b) \* \* \* (6)
- For Hospice elections beginning on or after October 1, 2026, the hospice must provide the individual (or representative) an election statement addendum, as set forth in paragraphs (c) and (d) of this section, **which includes any conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice.**



# Hospice Election Statement and Addendum

- Content of hospice election statement addendum.
  - The election statement addendum (and its updates) must include the following:
    - Name and signature of the individual (or representative) and date signed
    - A statement that **signing this addendum (and its updates) is only acknowledgement of receipt of the addendum and not the individual's (or representative's) agreement with the hospice's determinations.**
    - If the individual (or representative) **refuses to sign the addendum, the hospice must document on the addendum the reason the addendum was not signed** and the addendum would become part of the patient's medical record.
    - The addendum must also be **available for non-hospice providers and Medicare contractors,** although non-hospice providers and Medicare contractors are not required to sign the addendum



# Hospice Election Statement and Addendum

- Date the hospice furnished the addendum to the individual (or representative).
- Timeframes for the hospice election statement addendum.
  - For hospice elections **beginning on or after October 1, 2026**, the hospice must provide the individual (or representative) an election statement addendum, in writing at the time of the hospice election (that is, **within the first 5 days of the effective date of the hospice election**).
  - The hospice must also file this information with the election statement, to be available for the individual (or representative), non-hospice providers, and Medicare contractors.
- **Changes to the plan of care** during the course of hospice care that impact the addendum determinations,
  - the hospice **must update the addendum, within 3 days**, with the contents previously described and
  - provide these updates, in writing, to the individual (or representative), as well as
  - update the addendum on file in order to communicate these changes to the individual (or representative), non-hospice providers, and Medicare contractors.



# Hospice Election Statement and Addendum

- If the individual dies, revokes, or is discharged within the required timeframe for providing the addendum (and its updates) and before the hospice has provided the addendum (and its updates),
  - The addendum would not be required to be provided, in writing, to the individual (or representative).
  - the addendum would not be required to be signed in order for the hospice to receive payment.
  - The hospice must note the reason the addendum (and its updates) was not completed and/or provided, in writing, to the individual (or representative) and this note would become part of the patient's medical record.
  - **If completed**, the hospice must still **file the addendum (and its updates) with the election statement**, as set forth in paragraphs (a) and (b) of this section, to be available for the individual (or representative), non-hospice providers, and Medicare contractors.



# Discharge from Hospice

- §418.26 Discharge from hospice care.
  - Discharge order.
    - Prior to discharging a patient for
      - The patient moves out of the hospice's service area or transfers to another hospice;
      - The hospice determines that the patient is no longer terminally ill; or
      - The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements
    - Hospice must obtain a written physician's discharge order from the hospice medical director (or physician designee, or physician member of the interdisciplinary group. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.



# National Regulatory Focus

**Service and Spending Variation Index-"SSVI"**

**PEPPER Report**

**National Moratorium**

**Fraud Task Force**

**CMS Payment Suspensions**



# Service and Spending Variation Index-"SSVI"

- Service and Spending Variation Index ("SSVI")
  - New Fraud/Compliance Risk assessment
  - Metrics collected from claims data that can signal potential inappropriate utilization, quality of care, or compliance concerns
  - Scores range from 0-16 (Low score is GOOD, High = BAD)
  - CMS is soliciting comments on the metrics and the scoring system of the SSVI.
  - Resource Page: <https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospiceregulations-and-notices/cms-1851-p>



# Proposed Rule and SSVI Resources: CMS 1851-P

The screenshot shows the CMS.gov website page for regulation CMS-1851-P. The URL in the browser is <https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice-regulations-and-notices/cms-1851-p>. The page header includes the CMS.gov logo and navigation links for Medicare, Medicaid/CHIP, Marketplace & Private Insurance, Initiatives, and Training & Education. The main content area is titled 'CMS-1851-P' and includes the following details:

<b>Regulation No.</b>	CMS-1851-P
<b>Title</b>	FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements
<b>Display Date</b>	2026-04-02
<b>Publication Date</b>	2026-04-06

The FY 2027 hospice proposed rule with comment went on display at the Office of the Federal Register's Public Inspection Desk on April 2, 2026 and will be available until the regulation is published on April 6, 2026. See CMS-1851-P in the "Related Links" section below.

**Downloads**

- [FY 2027 Proposed Hospice Wage Index](#)
- [Expanded Parts B/D Non-Hospice Spending](#)
- [SSVI](#)
- [SSVI Overview](#)



# SSVI-Public Data is available!

A	B	C	D	E	F	G	H	I	J	K
CCN	Hospice Name	Year Hospice First Billed Medicare	Ownership	Facility Type	City	State	Hospice Address Urban/Rural (U/R)	Non-Hospice Spending Score (0 = Lowest and 8 = Highest)	Utilization Score (0 = Target Range and 8 = Highest Outliers)	SSVI (Service and Spending Variation Index) Score (0 = Target Range and 16 = Highest Outlier)
001500	Agave Hospice and Palliative Care	2022	For-profit	Freestanding	PHOENIX	AZ	U	7	1	8
001502	Family First Hospice, Inc	2022	For-profit	Freestanding	PHOENIX	AZ	U	4	3	7
001503	SAMARITAN HOSPICE INC	2022	For-profit	Freestanding	TEMPE	AZ	U	2	5	7
001504	Heart of Healing Hospice	2022	For-profit	Freestanding	CASA GRANDE	AZ	U	3	0	3
001505	ADVOCATE HOSPICE	2022	For-profit	Freestanding	PHOENIX	AZ	U	1	2	3
001509	Care Plus Hospice Care, Llc	2022	For-profit	Unknown	Scottsdale	AZ	U	2	3	5
001510	Family Care Hospice Inc	2022	For-profit	Freestanding	PHOENIX	AZ	U	4	4	8
001511	Copper State Hospice Inc	2022	For-profit	Freestanding	TUCSON	AZ	U	7	0	7
001513	Expert Hospice Care Inc	2022	For-profit	Freestanding	PHOENIX	AZ	U	6	4	10
001514	UNIVERSAL HOSPICE CARE SERVICES	2022	For-profit	Freestanding	PHOENIX	AZ	U	6	5	11
001515	PRISTINE HOSPICE LLC	2022	For-profit	Freestanding	GLENDALE	AZ	U	7	2	9
001516	Valleyside Hospice Inc	2022	For-profit	Unknown	SCOTTSDALE	AZ	U	0	1	1
001517	SUNSET HOSPICE LLC	2022	For-profit	Freestanding	TUCSON	AZ	U	5	2	7
001518	Ovation Hospice of Phoenix	2022	For-profit	Freestanding	Tempe	AZ	U	2	1	3
001521	OTIUM HOSPICE INC	2022	For-profit	Freestanding	TEMPE	AZ	U	3	4	7
001524	GOLDEN ROSE HOSPICE CARE INC	2022	For-profit	Freestanding	PHOENIX	AZ	U	2	5	7
001526	POLARIS HOSPICE LLC	2022	For-profit	Freestanding	GLENDALE	AZ	U	8	4	12



# Service and Spending Variation Index “SSVI”

## New “PEPPER”?

### KPI's To Track

Service & Spending Variation Index "SSVI" Rating Items	Threshold to Trigger Points (BAD)	National Ranking Threshold "percentile" to trigger point	Example Agency 2025 Health Pivot Ranking	Example Agency 2025 SHP Ranking	SHP Data source
Hospice's percentage of discharges that are live is greater than or equal to the 75th Percentile (46.7%) <b>(includes: Revoked, Moved, No Longer Terminal, DC Cause)</b>	>46.7%	75%	17%	21-27%	(live DC's/Deaths + live DC's) OR (Live DC/Deaths) (Scorecard)
Hospice's rate of providing visits during the last two RHC days of life that is less than or equal to the 25th Percentile (87.5%) <b>(includes: RN, LVN, MSW, Therapy)</b>	<87.5%	25%	80.90%	76.9	(HVND SHP Scorecard) OR Manual Review for HVND
Hospice has 40% or more of RHC days provided in a nursing home or skilled nursing facility	>40%	NA	4%	20%	Site of Service at Admission (add up ALF + LTC + SNF) (Hospice Executive advantage)
Hospice has no days of CHC and no days of GIP	NO DAYS	NO DAYS	0 days	0.40%	HCI: CHC or GIP Provided (HRQP report)
Hospice's average skilled nursing minutes on RHC days is less than or equal to the 25th Percentile (9.9 minutes per day)	<9.9 minutes/day	25%	16.9 min	15.7 min	HCI: SN Minutes Per RHC Day (HRQP report)
Hospice's percentage of weekend RHC days with a skilled visit <b>(includes: nursing, MSW, therapy)</b> is less than or equal to the 25th Percentile (4.8%)	<4.8%	25%	6%	8%	HCI: Percent of SN minutes on Weekends (HRQP report)
Hospice's percent of live discharges where beneficiaries return to the same hospice in seven days is greater than or equal to the 75th Percentile (18.2%) <b>(Includes all DC reasons (transfers included))</b>	>18.2%	75%	0%	UNK	TBD
Hospice's percentage of discharges with a LOS of 180 days or more is greater than or equal to the 75th Percentile (33.3%) <b>(includes: Revoked, Moved, No Longer Terminal, DC Cause)</b>	33.00%	75%	22%	25%	HCI Late Live DC's (HRQP report)
Non-Hospice Spending	Sliding Scale 0-8 Points	-	6	UNK	TBD



# SSVI- **New PEPPER?** Non-Hospice Spending Sliding Scale

Non-Hospice Spending Score	FY2025 Thresholds		FY2024 Thresholds	
	Non-Hospice Spending is Greater than this Amount	Non-Hospice Spending is Less than or Equal to this Amount	Non-Hospice Spending is Greater than this Amount	Non-Hospice Spending is Less than or Equal to this Amount
0	\$0.00	\$0.00	\$0.00	\$0.00
1	\$0.00	\$6,352.84	\$0.00	\$5,964.19
2	\$6,352.84	\$20,612.10	\$5,964.19	\$19,061.63
3	\$20,612.10	\$42,911.79	\$19,061.63	\$41,318.35
4	\$42,911.79	\$76,801.05	\$41,318.35	\$72,896.46
5	\$76,801.05	\$133,440.80	\$72,896.46	\$124,893.05
6	\$133,440.80	\$246,123.06	\$124,893.05	\$227,185.05
7	\$246,123.06	\$517,204.41	\$227,185.05	\$520,100.16
8	\$517,204.41		\$520,100.16	

\*Exceptions = day of DC and day of admission to hospice are excluded from Non-Hospice spending analysis\*



# SSVI- **New PEPPER?**

## Non-Hospice Spending

### Hospice National Rankings- Where are you?

**TABLE 10: Distribution of SSVI Score for Hospices in FY 2024 and FY 2025 Hospice Claims**

Total Score	FY 2024		FY 2025	
	Number of Hospices	Percent of Hospices	Number of Hospices	Percent of Hospices
0	6	0.1%	4	0.1%
1	91	1.4%	87	1.3%
2	334	5.0%	332	5.0%
3	564	8.4%	527	7.9%
4	760	11.3%	714	10.7%
5	838	12.4%	887	13.4%
6	918	13.6%	890	13.4%
7	862	12.8%	898	13.5%
8	920	13.7%	899	13.5%
9	629	9.3%	571	8.6%
10	366	5.4%	407	6.1%
11	255	3.8%	230	3.5%
12	116	1.7%	122	1.8%
13	48	0.7%	55	0.8%
14	28	0.4%	18	0.3%
15	0	0.0%	1	0.0%
16	0	0.0%	0	0.0%
<b>Total Hospices</b>	<b>6,735</b>	<b>100.0%</b>	<b>6,642</b>	<b>100.0%</b>



# Non-Hospice Spending- Categories

<b>Table 2. Concurrent Payments for Services Provided to Hospice Beneficiaries (All Claim Types), FY2024</b>		
<b>Claim Type</b>	<b>Total Payment</b>	<b>Percent of Payment</b>
DME	\$68,269,227	2.4%
HHA	\$20,575,467	0.7%
Inpatient	\$193,298,218	6.7%
Outpatient	\$202,855,467	7.0%
Carrier	\$1,562,873,679	54.3%
SNF	\$17,663,078	0.6%
Part D	\$813,107,801	28.2%
<b>Total</b>	<b>\$2,878,642,937</b>	<b>100.0%</b>
<b>DME, Carrier, &amp; Part D</b>	<b>\$2,444,250,707</b>	<b>84.9%</b>
<b>DME &amp; Carrier</b>	<b>\$1,631,142,906</b>	<b>56.7%</b>



# NON-Hospice Spending- Top 10 sub-categories

## For Reference Only

**Table 5. Concurrent Payments for Services Provided to Hospice Beneficiaries (DME & Carrier Claims) by Diagnosis & Restructured BETOS Classification System Subcategory, FY2024**

RBCS Category	RBCS Subcategory	Neuro/Degenerative	Heart/CVA	Respiratory	Cancer	All Other	Total
DME	Medical/Surgical Supplies	\$399,888,551	\$402,094,798	\$50,918,403	\$45,825,410	\$185,308,573	\$1,084,035,739
E&M	Care Management/Coordination	\$6,410,748	\$5,047,549	\$1,310,895	\$1,466,819	\$2,373,871	\$16,609,883
E&M	Home Services	\$25,379,455	\$18,678,159	\$2,666,495	\$3,031,606	\$5,863,391	\$55,619,107
E&M	Hospital Inpatient Services	\$3,584,661	\$6,945,729	\$3,102,091	\$4,273,374	\$4,678,522	\$22,584,377
E&M	Nursing Facility Services	\$38,714,974	\$34,157,272	\$6,803,221	\$9,660,843	\$16,769,948	\$106,106,260
E&M	Office/Outpatient Services	\$6,224,171	\$9,539,287	\$2,594,247	\$3,949,828	\$3,881,910	\$26,189,442
Other	Ambulance	\$18,400,764	\$21,352,861	\$6,374,160	\$9,802,317	\$9,339,524	\$65,269,626
Procedure	Skin	\$23,543,151	\$21,087,317	\$2,915,149	\$3,766,056	\$8,941,102	\$60,252,773
Test	Molecular Testing	\$10,184,654	\$10,354,238	\$2,181,485	\$4,428,787	\$3,640,610	\$30,789,775
Treatment	Injections and Infusions (nononcol)	\$8,825,544	\$13,524,540	\$2,942,383	\$4,201,940	\$5,293,001	\$34,787,407



# NON-Hospice Spending- Top 10 Medication Categories

## For Reference Only

Table 9. Concurrent Payments for Services Provided to Hospice Beneficiaries (Part D) by Diagnosis & Therapeutic Category, FY2024

Therapeutic Category	Neuro/Degenerative	Heart/CVA	Respiratory	Cancer	All Other	Total
ANTIARTHRITICS	\$4,427,324	\$8,107,718	\$3,149,919	\$1,591,304	\$3,715,486	\$20,991,752
ANTICOAGULANTS	\$33,334,371	\$55,387,069	\$12,868,779	\$13,348,612	\$15,587,452	\$130,526,280
ANTINEOPLASTICS	\$4,452,136	\$9,882,294	\$2,899,960	\$15,031,606	\$2,740,744	\$35,006,741
ANTIVIRALS	\$2,563,753	\$7,207,822	\$2,676,625	\$3,559,843	\$5,709,745	\$21,717,787
ATARACTICS-TRANQUILIZERS	\$38,020,209	\$10,819,758	\$4,146,299	\$2,990,574	\$6,302,132	\$62,278,974
BRONCHIAL DILATORS	\$5,367,533	\$13,794,679	\$24,066,160	\$7,354,661	\$6,214,514	\$56,797,547
DIABETIC THERAPY	\$20,691,367	\$54,412,031	\$11,736,379	\$9,857,734	\$14,586,170	\$111,283,679
MISCELLANEOUS	\$25,264,417	\$28,739,294	\$11,011,439	\$7,570,381	\$41,726,616	\$114,312,147
OPHTHALMIC PREPARATIONS	\$6,403,828	\$8,997,885	\$1,695,290	\$1,873,379	\$3,708,988	\$22,679,371
OTHER CARDIOVASCULAR PREPS	\$4,410,301	\$10,284,306	\$2,359,706	\$1,984,410	\$2,321,586	\$21,360,309



# NON-Hospice Spending- Top 35 Medications

## For Reference only

**Table 10. Concurrent Payments for Services Provided to Hospice Beneficiaries (Part D) by Diagnosis & National Drug Code, FY2024**

Therapeutic Category	NDC	NDC Name	Neuro/Degenerat	Heart/CVA	Respiratory	Cancer	All Other	Total
ADRENERGICS	00469260130	MYRBETRIQ	\$1,188,001	\$1,210,685	\$355,620	\$301,564	\$470,033	\$3,525,904
ADRENERGICS	00469260230	MYRBETRIQ	\$1,310,449	\$1,267,746	\$363,343	\$373,137	\$458,603	\$3,773,279
ANTIARTHRITICS	00074055402	HUMIRA(CF) PEN	\$945,625	\$1,366,711	\$517,580	\$170,721	\$935,107	\$3,935,744
ANTIARTHRITICS	58406003204	ENBREL SURECLICK	\$826,081	\$1,226,895	\$478,837	\$229,614	\$557,853	\$3,319,281
ANTICOAGULANTS	00003089321	ELIQUIS	\$12,547,794	\$20,801,381	\$3,367,725	\$3,353,882	\$5,820,749	\$45,891,528
ANTICOAGULANTS	00003089421	ELIQUIS	\$13,214,717	\$23,141,486	\$6,852,788	\$7,166,679	\$6,472,470	\$56,848,140
ANTICOAGULANTS	50458057830	XARELTO	\$1,193,490	\$2,162,854	\$308,135	\$336,576	\$481,415	\$4,482,470
ANTICOAGULANTS	50458057930	XARELTO	\$1,763,808	\$2,502,092	\$712,206	\$841,120	\$775,441	\$6,594,668
ANTICOAGULANTS	50458057990	XARELTO	\$1,181,841	\$1,485,656	\$402,365	\$363,382	\$456,867	\$3,890,110
ANTIVIRALS	61958250101	BIKTARVY	\$707,629	\$2,470,967	\$1,108,887	\$1,302,563	\$1,887,648	\$7,477,693
ATARACTICS-TRANQUILIZERS	50458056401	INVEGA SUSTENNA	\$1,031,396	\$782,367	\$501,654	\$405,509	\$609,627	\$3,330,553
ATARACTICS-TRANQUILIZERS	63090034030	NUPLAZID	\$24,056,717	\$2,307,491	\$507,198	\$433,505	\$1,199,231	\$28,504,144
BRONCHIAL DILATORS	00173088710	TRELEGY ELLIPTA	\$729,303	\$2,307,803	\$5,192,929	\$1,576,168	\$1,085,270	\$10,891,473
BRONCHIAL DILATORS	00173089310	TRELEGY ELLIPTA	\$263,313	\$1,121,006	\$3,392,220	\$845,018	\$591,433	\$6,212,990
BRONCHIAL DILATORS	00310461612	BREZTRI AEROSPHERE	\$145,617	\$579,028	\$2,021,276	\$534,867	\$334,592	\$3,615,380
DIABETIC THERAPY	00002143380	TRULICITY	\$789,232	\$1,991,623	\$421,806	\$266,613	\$524,662	\$3,993,936
DIABETIC THERAPY	00002143480	TRULICITY	\$621,024	\$1,475,675	\$348,379	\$269,654	\$431,937	\$3,146,670
DIABETIC THERAPY	00006027731	JANUVIA	\$1,343,864	\$2,521,856	\$394,843	\$510,150	\$723,610	\$5,494,323
DIABETIC THERAPY	00088221905	LANTUS SOLOSTAR	\$830,200	\$2,027,070	\$467,392	\$401,167	\$625,147	\$4,350,976
DIABETIC THERAPY	00169418113	OZEMPIC	\$424,165	\$2,112,234	\$596,613	\$207,472	\$475,288	\$3,815,773
DIABETIC THERAPY	00310621030	FARXIGA	\$879,925	\$4,120,285	\$757,851	\$617,499	\$919,769	\$7,295,329
DIABETIC THERAPY	00597014030	TRADJENTA	\$1,251,804	\$1,912,366	\$358,254	\$390,291	\$542,914	\$4,455,629
DIABETIC THERAPY	00597015230	JARDIANCE	\$1,040,655	\$4,895,404	\$912,153	\$738,412	\$912,538	\$8,499,162
DIABETIC THERAPY	00597015290	JARDIANCE	\$469,796	\$1,806,146	\$391,396	\$300,757	\$351,809	\$3,319,905
DIABETIC THERAPY	00597015330	JARDIANCE	\$811,281	\$3,017,016	\$572,507	\$527,972	\$746,124	\$5,674,900
ENZYMES	00032301613	CREON	\$1,349,683	\$1,555,663	\$390,310	\$1,040,302	\$1,214,495	\$5,550,454
ENZYMES	50484001030	SANTYL	\$3,397,953	\$3,678,217	\$376,440	\$582,580	\$1,757,995	\$9,793,187
MISCELLANEOUS	00024591502	DUPIXENT PEN	\$836,408	\$1,153,209	\$654,412	\$439,576	\$475,608	\$3,559,214
MISCELLANEOUS	00069873030	VYNDAMAX	\$677,607	\$5,842,323	\$422,453	\$735,284	\$2,496,128	\$10,173,794
MISCELLANEOUS	00456120130	LINZESS	\$1,306,310	\$1,617,629	\$497,723	\$398,714	\$634,817	\$4,455,194
MISCELLANEOUS	00597014360	OFEV	\$99,381	\$345,971	\$772,321	\$106,878	\$2,562,652	\$3,887,204
MISCELLANEOUS	00597014560	OFEV	\$11,494	\$766,098	\$939,229	\$379,980	\$2,975,685	\$5,072,487
MISCELLANEOUS	64597030160	NUEDEXTA	\$2,593,650	\$1,545,948	\$149,190	\$86,076	\$971,513	\$5,346,377
MISCELLANEOUS	68546017260	AUSTEDO	\$1,026,879	\$921,920	\$290,839	\$287,698	\$5,267,737	\$7,795,074
MISCELLANEOUS	70370108001	INGREZZA	\$2,598,809	\$1,686,865	\$983,114	\$581,143	\$1,871,101	\$7,721,033



# SSVI Triggers and Non-Hospice Spending Behavior Changes?

- Behavior Changes for Non-Hospice Spending:
  - Less Patients accepted that aren't in line with "Hospice Philosophy" (i.e. High Risk to re-hospitalize)
  - Increase in Patients dying at Hospital?
  - Increase in patient revocations?
- Majority of Spending Categories:
  - Wound Care (Skin Substitutes)
  - Medications (Anti-coagulants, Beta Blockers, Anti-Hypertensives)
  - DME (WC, Oxygen, Hospital Beds)
  - ER Stays/Hospitalizations
- Reminder:
  - All Meds MUST be covered 100% in the below categories:
    - Pain Relievers
    - Anti-Nausea
    - Laxatives
    - Anti-Anxiety



# SSVI Triggers and Non-Hospice Spending: Consequences & Key Process Review

- Thresholds to trigger review
  - Not Yet Established
  - Possible bottom 25<sup>th</sup> percentile (~ 8-9/16 SSVI Score)
- Consequences of Poor Scores:
  - ADR's- Medical Review?
  - TPE?
  - Suspension of license?
  - Termination of License?
- Process to review:
  - Claims Process (All Visits landing on claims, Therapy?)
  - Claims Codes (DC codes 01 (home), 50 (Tx), 51 (Tx), 41 (RIP), 42 (RIP), 43 (RIP), 30 (Cont. HSP))
  - Non-Spending Categories (Meds, ER/Hospitalizations, Non-Covered Items)
  - High Risk For Re-Hospitalization Procedures
  - Hospice Philosophy
  - Visits Near Death
  - Long LOS Eligibility Discussions (Enter 3rd benefit period?)



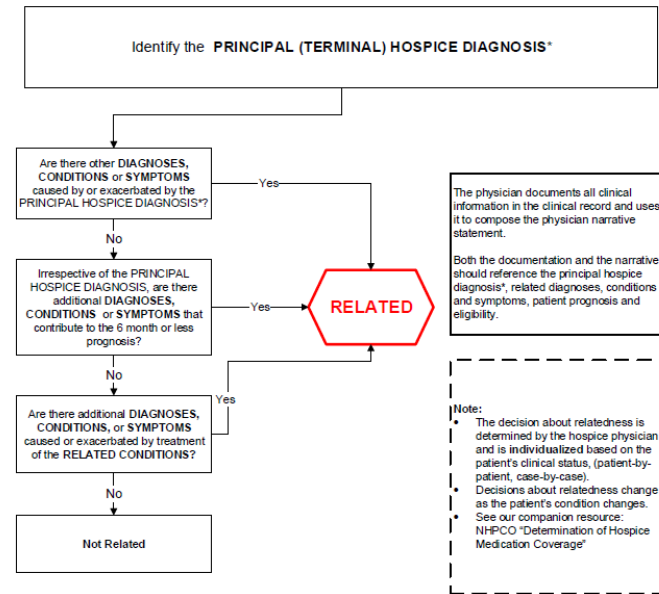
# NHPCO's resources: Related Vs. Un-Related Conditions For Reference only

Determining Relatedness to the Terminal Prognosis Process Flow



- Physician uses all available clinical information to evaluate for:
- Terminal prognosis of 6 months or less
  - Terminal and related diagnoses that contribute to the terminal prognosis -- all diagnoses that impact the terminal prognosis
  - Symptoms caused or exacerbated by terminal diagnosis, related diagnosis or treatment of terminal and related diagnoses

Note: Per the Centers for Medicare and Medicaid Services (CMS) virtually all diagnoses are related to the terminal prognosis. A diagnosis is considered to be related unless the hospice physician documents in the hospice clinical record why that diagnosis is not related. Determining relatedness is a continuous process by the hospice physician which takes into account the changes in the patient's condition.



**The following are used as equivalent terms:**  
 terminal hospice diagnosis = principal hospice diagnosis = primary terminal diagnosis = primary hospice condition  
 Out of all the prognosis-impacting diagnoses, this is the diagnosis reported to CMS.  
 All diagnoses related and unrelated should be reported.

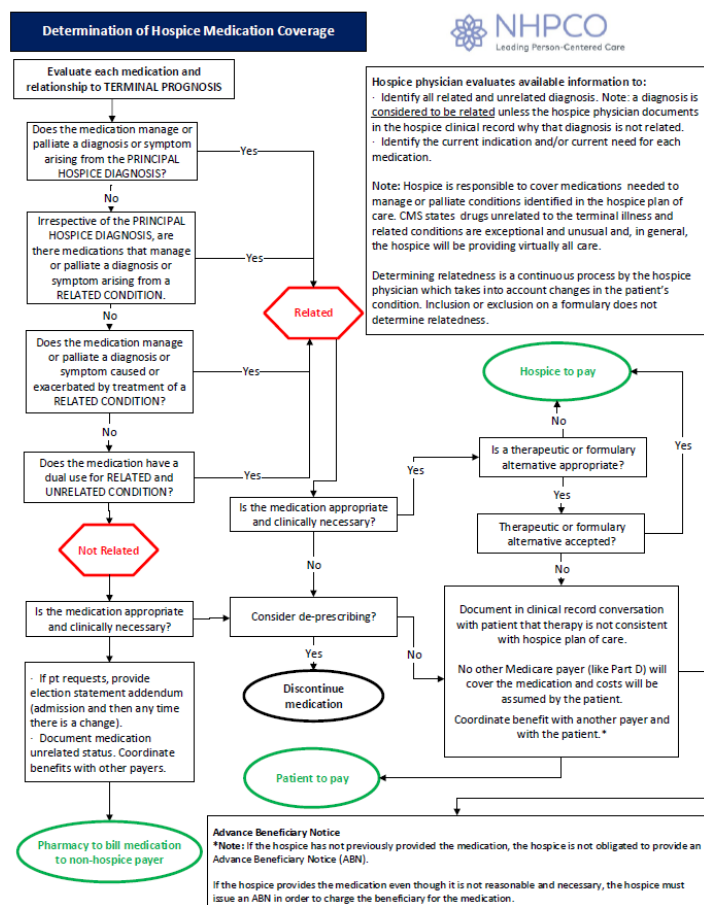
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# NHPCO's resources

## Covered vs. non-covered

### For Reference only



# CMS Resources

## Discharge Claim Codes

### For Reference only

Status Code	Description
01	Discharged to home or self-care
30	Still a patient (for continuing hospice care for same Medi-Cal member)
40	Expired at home
41	Expired in a medical facility, such as a hospice, Nursing Facility Level A, Nursing Facility Level B, or freestanding hospice
42	Expired, place unknown
50	Discharged/transferred to hospice, home
51	Discharged/transferred to hospice, medical facility



# PEPPER IS BACK

The Hospice PEPPER report for 2026 was released by CMS on June 3, 2026, covering FY 2023 through FY 2025.

## Overview

- The **Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER)** is a Microsoft Excel-based tool that summarizes three years of provider-specific Medicare data statistics for target areas associated with potential improper payments. The 2026 Hospice PEPPER allows hospices to compare their data with other hospices nationwide, within their Medicare Administrative Contractor (MAC) jurisdiction, and at the state level, helping identify trends, auditing priorities, and potential payment issues (CMS, June 3, 2026)

## Coverage and Target Areas

- The 2026 Hospice PEPPER includes **15 target areas** identified by CMS after analyzing national hospice claim data. These target areas highlight areas within the hospice benefit that may be at risk for improper Medicare payments. Each target area includes detailed information such as numerator, denominator, and measure descriptions to guide auditing and compliance efforts.



# PEPPER (cont.)

## Usage and Benefits **WHY YOU SHOULD REVIEW IT NOW**

- Hospices can use the PEPPER report to:
  - Identify **data trends** : Utilization patterns, changes in LOS and potential areas for auditing and monitoring.
  - Detect **coding or billing issues** that may lead to improper payments.
  - Compare performance against **national, MAC, and state benchmarks**.
  - Support **compliance, documentation improvement, and case management** initiatives.
  - Prioritize areas for **internal audits and monitoring** to reduce risk of overpayments or underpayments

**Make sure that you have access to the PEPPER Portal**



# National Moratorium - May 13, 2026

- Vice President Vance's Anti-Fraud Task Force
  - CMS taking decisive action to protect Medicare beneficiaries & taxpayer dollars
- **Aggressive Nationwide Crackdown on Fraud**
  - **Six-Month day-driven Hospice and Home Health Agency Enrollment Moratoria**
  - May be extended in six-month increments if CMS deems it necessary
  - No new hospices unless enrollment received by contractor prior to May 13, 2026
  - No new multiple location



# DOJ Forms Health Care Task Force

- US Department of Justice (DOJ) National Fraud Enforcement Division
  - [West Coast Health Care Fraud Strike force](#)
    - Multidistrict enforcement initiative
      - Department of Health and Human Services Office of Inspector General (HHS- OIG)
      - US Attorney's Offices for Arizona, Nevada, northern District of California
      - US Drug Enforcement Administration (DEA)
      - FBI
    - Utilize advanced data analysis
      - Technology Hubs
      - Billing patterns
      - Schemes across jurisdictions



# Hospice Payment Suspensions

- Began in April 2026 (letters sent)
- Effecting 447 hospices and 23 home health agencies
  - May 17th Dr Oz states 800 hospice providers suspended (1 Billion Medicare fraud scheme)
- Based on credible allegation of fraud
  - 2025-2026 live discharge rates 53%
- Providers have 15 business days to submit a rebuttal to the suspension
- **\*\*\*\* Session is scheduled on Thursday at 10:15am for more details \*\*\*\***



# Deep Breath- This is a marathon not a sprint! Orientation and Annual Training Requirement



# Orientation and Annual Education Requirements-California Proposed Rule

*Administrator & Designee*

*Director of Patient Care Services & Designee*

*Medical Director & Designee*



# Orientation Requirements



## Hospice Management

Administrator & Designee

Medical Director & Designee

Director of Patient Care Services & Designee



## Experience

New – First time (never designated or served in role at a hospice in California)

Experienced – Previous served in role or as a designee at a hospice in California)



# Training Program Requirements- “this is how you can get it done”!

- Training or certification programs completed by hospice management personnel must be:
  - Structured
  - Formalized classes
  - Correspondence courses
  - Competency based computer courses (Elsevier, Relias, Med bridge, others...)
  - Training videos
  - Distance learning programs (CAHSAH CERTIFICATION PROGRAMS)
  - Off-site training courses (CAHSAH CERTIFICATION PROGRAMS, ANNUAL CONFERENCE, WORKSHOPS)
  - **If training or certification program is not provided by the hospice. It must be provided by a certified or accredited training provider**



<b>Administrator/Administrator Designee</b>
<b>First Time (Never designated or served as Administrator or Designee at hospice in California)</b>
<b>First 12 months (24 hrs.)</b>
<b>Hospice Management: Included but not limited to:</b>
<b>Hospice Management</b>
Hospice operations, administration, and services
Human Resources Management Personnel Onboarding
Hospice Regulatory Requirements
Hospice quality assessment & performance improvement
<b>OR</b>
<b>Certification Program</b>
Identifying new practices to integrate quality assessment and performance improvement goals
Understanding financial management, planning, and operations
Hospice Regulatory Requirements



**First Time (Never designated or Served as DPCS  
in a hospice in California)**

**First 12 months (24hrs)**

**Clinical Management of a hospice including  
but not limited to:**

**Hospice Clinical Management**

Providing clinical direction and support for  
hospice staff, hospice patients and the  
patient's family and representatives  
Effective leadership and communication  
Ethical and professional conduct

Hospice Regulatory requirements

**OR**

**Certification Program**

Patient care assessment & planning

Patient care pain & symptom management  
Support, education and advocacy for  
patients, as well as patient's representatives,  
caregivers and family

Regulatory compliance and practical  
considerations



<b>Medical Director/Designee</b>
<b>First Time (Never designated or served as Medical Director or Designee at hospice in California)</b>
<b>First 12 months (24 hrs.)</b>
<b>Hospice Clinical Management Included but not limited to:</b>
<b>Hospice Clinical Management</b>
Providing medical direction and support for hospice patients, and the patient's family and representatives
Effective leadership and Communication
Ethical and professional conduct
<b>Hospice regulatory requirements</b>
<b>OR</b>
<b>Certification Program</b>
Providing medical direction and support for hospice patients and the patient's family and representatives
to, medication, and pain management, assessing and managing diagnosis and symptoms, hospice settings and patient assessments
Medical leadership and communication, including but not limited to, on-going support and education of hospice personnel
Ethical and professional conduct
<b>Hospice regulatory requirements</b>



**Hospice Management Personnel (Administrator, DPCS, Medical Director and Designees)**

**Minimum of 20 hrs. new hire orientation within 60 days as provided by the hospice.**

**Hospice Provided**

**Minimum of 1 hr. total:** Reviewing, identifying and discussing the administrative, oversight, and investigative responsibilities of the following public entities:

California Department of Public Health  
California Department of Justice, Office of Attorney General  
California Department of Health Care Services  
California Department of Social Services  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services, Office of Inspector General  
U.S. Department of Justice.

**Minimum of 1 hr. total:** Reviewing, identifying, and discussing the Department's current licensing requirements including but not limited to:

Health and Safety Code, Division 2, Chapter 8.5  
Title 22 of the California Code of Regulations, Division 5, Chapter 6.5  
All applicable requirements for initial licensure, inspections, change in ownership, report of changes, multiple locations, and license renewals pursuant to Article 2 . License, of this chapter (**DPH-18-002E Page 10-46**)

**Minimum of 6 hrs. total:** Total review of the following:

Basic hospice services, including but not limited to: (**Standards of Quality Hospice Care 2005 Article 2. Services 2.1-2.8**)

1. Physician qualifications & responsibilities, including but not limited to, the hospice Medical Director, hospice physician and attending physician
2. skilled nursing and licensed vocational nursing personnel qualifications & responsibilities **DPH-18-002E Article 3. Services Section 74848 Page 47-50**
3. Social work and counseling personnel qualifications and responsibilities
4. Volunteers qualifications & responsibilities
5. Home health aide/ Homemaker qualifications
6. Inpatient Care Arrangements

Hospice administration, including but not limited to:

1. The responsibilities \* administrative policies of the hospice governing body, including development, administration and required content
2. The responsibilities and qualifications of the hospice Administrator, Director of Patient Care Services & Medical Director **DPH-18-002E Section 74852, Director of Patient Care Services Page 51-52, Section 74856, Medical Director Page 53-54, Article 5. Administration Section 74876, Page 66-67**



## HOSPICE MANAGEMENT PERSONNEL (CONT)

Human Resource management, including but not limited to:

1. The American with Disabilities Act, Civil Rights Act of 1991, The Rehabilitative Act of 1993, & Family & Medical Leave Act of 1993.
2. Employee & volunteer requirements, including but not limited to, state and federal exclusion lists, health screenings, initial and annual competency evaluations, orientation & education.
3. written agreement content requirements for contracted services including but not limited to vendor, facility and provider services
4. The requirements for human resources policies and procedures & how they will be implemented.

**Minimum of 6 hrs. total:** Reviewing hospice policies & procedures, including but not limited to:

The hospice's emergency preparedness plan, including but not limited to:

1. Risk assessment
2. Training & testing
3. Implementation
4. Communication plan
5. Evaluation
6. Compliance with state and federal statutory & regulatory requirements

Hospice's Infection Control program, including but not limited to:

1. Infection control education to personnel, contracted providers, volunteers, Patients, and patient's families, & caregivers on the science of infection
2. Preventative measure minimize the spread of infections & communicable diseases through daily activities such as hand hygiene, respiratory hygiene, cough etiquette & the use of personal protective equipment
3. Surveillance & monitoring for compliance with the hospice policies & procedures related to infection control
4. Reporting all cases of outbreak or undue prevalence of infections or parasitic disease or infestation to the local health officer & the Department in accordance with applicable law
5. measures for investigating outbreaks

Complaint management including but not limited to

1. Documentation required for hospice patients or patient's families to submit a complaint
2. Investigation and review of received complaints
3. Follow-up requirements to resolve a complaint
4. Safety management, such as real or potential threats to the health or safety of personnel or patients
5. Criminal misconduct, including investigation & reporting requirements of abuse, neglect, and exploitation to the appropriate law enforcement agency



## HOSPICE MANAGEMENT PERSONNEL (CONT)

Fraud, waste & abuse including but not limited to :

1. Training personnel, contracted providers & volunteers on how to prevent fraud, waste and abuse. Personnel, contractors and volunteers must be trained on how & when to report instances or allegations of fraud, waste & abuse in accordance with applicable state & federal reporting requirements
2. Surveillance & monitoring for compliance with hospice policies & procedures related to fraud, waste & abuse
3. Patient rights & protection from retaliation by personnel, contracted providers, or volunteers

Patient Medical Records, including but not limited to:

1. Required content, pursuant to section 74892
2. Proper documentation of services, pursuant to section 74892
3. Proper storage & maintenance, pursuant to section 74892 & 74896
4. The Health Insurance Portability & Accountability Act requirements, including but not limited to, the privacy rule requirements pursuant to Title 45 of the Code of Federal Regulation parts 160 & 164, subparts A&E, the security rule requirements pursuant to Title 45 of the Code of Federal Regulations parts 160 & 164, subpart (A) & (C), the breach notification rule requirement pursuant to Title 45 of the Federal Regulations Part 164 subpart (D) & confidentiality of substance use disorder patient records pursuant to Title 42 of the Code of Federal Regulations part 2, subpart (A), if applicable
5. California confidentiality laws including but not limited to the confidentiality of medical information requirements pursuant to the Confidentiality of Medical Information Act; medical breach reporting requirements pursuant to Health & safety Code section 1280.15; patient rights to access health records pursuant to Health & Safety Code Division 106. Part 1; patient human immunodeficiency virus testing protections pursuant to Health & Safety Code Division 105. Part 4, Chapter 7; and the Information Practice Act of 1977, if applicable

Controlled Substance management, including but not limited to:

1. Prescribing
2. Dispensing
3. Administering
4. Accountability, including but not limited to, receipt & reconciliation of controlled substances



## HOSPICE MANAGEMENT PERSONNEL (CONT)

**Minimum of 6 hrs. total:** Reviewing hospice patient care requirements, including by not limited to;

Hospice Admission

Patient Rights & Responsibilities including but not limited to

1. Policies & procedures
2. Required notifications including but not limited to, changes in advanced directives, change in address or telephone number, or a problem or dissatisfaction with patient care
3. Uniform Health Care Decision Act requirements
4. California End of Life Option Act requirements

Initial & comprehensive assessments pursuant to section 74864 subdivision (a) & (b)

Plan & coordination of care pursuant to section 74869

Live discharge or transfer

Patient discharge by death

**New hire orientation training must include a minimum of one additional hour if the hospice maintains optional services including by not limited to PT, OT and SLT. Training must include information on qualifications & responsibilities of all personnel of those services**



# Hospice Management Personnel (Administrator, Medical Director & Director of Patient Care Services & Designees)

**New hire orientation training must include a minimum of one additional hour if the hospice maintains optional services including but not limited to PT, OT and SLT. Training must include information on qualifications & responsibilities of all personnel of those services**

**\* Management Personnel hired prior to the promulgation of these regulations are exempt from this training requirement.**



## Hospice Management Personnel

**12 hours Annual (12 month period from start date) training in addition to Subsection (d)**

**Minimum of 6 hrs. total** Reviewing hospice policies & procedures, including but not limited to  
Hospice's emergency preparedness plan

Infection Control program

Complaint management

Fraud, waste and abuse

Patient medical records **DPH-18-002E Section 74888: Medical Record, Section 74892 : MR Content, Section 74896 MR Use & Access , Section 74900 Electronic Health Record**

Controlled substances

**Minimum of 6 hrs. total** Hospice care requirements Subsection (d) (5)

Hospice Admission

Patient Rights and Responsibilities, including but not limited to:

1. Policies and Procedures
2. Required notifications including, but not limited to, change in advanced directives, change in address or telephone number, or a problem or dissatisfaction with patient care.
3. Uniform Health Care Decisions Act Requirements
4. California End of Life Options Act

Initial and comprehensive assessments pursuant to section 7464 subdivision (a) and (b) **DPH-18-002E Page 58-60**

Plan and coordination of care pursuant to section **74868 DPH-18-002E Pages 61-64**

Live patient discharge or transfer

Patient Discharge by Death



# Where do I start????

- Review your current Orientation Checklist
- Utilize these slides to add missing topics
- The slide sections are color coded identifying overlapping topics across all requirements.
- Develop or research available workshops, certifications, conferences, and on-line courses
- CAHSAH Manager and Administrator Certification Program will cover annual education requirements
- CAHSAH is developing on-demand courses on required topics



# What to Do NOW

- Review current Administrator, DPCS, and Medical Director orientation checklist to assure all required topics are included.
- Create two initial checklist:
  - New Managers with no experience in hospice in CA
  - Experienced Managers
- Review Annual Education Requirements
  - Do you currently have education to cover those topics (including the hours requirement)
  - CAHSAH will include the required 12 months educational requirements in the annual Manager Certification Program
  - CAHSAH will also have on-demand programs cover the topics



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# What Do You Remember????

- What roles are required specific hours of orientation and annual training?
- Who is a first-time manager?
- How many education hours are required annually?



Remember ....

This is Your  
Management Team

Give them a good  
foundation with  
orientation & education



# Opportunities to Thrive: KPI's, Compliance Items, Policy Suggestions

- Key Performance Indicator's ("KPI")
- Policy Suggestions
- Your Roadmap to Prepare



# Increase Opportunities to thrive

- How will I have time to increase opportunities?
- How will all this increase referrals, help recruit?
- Leadership and managers must know the regs and get certified—we are all on equal playing ground!
- Understand data is driving CMS decisions
- Leadership drives compliance



# Summary Recommendations AND OPPORTUNITIES:

## Policy Creation or Review/Update

### Leadership Policies and Procedures

- Application process/Content
- CHOW application timelines
- Who Designates ADMIN, MD DIRECTOR, DPCS

### Operational Expansion Procedures

- Determining Un-Met Needs +.....
- Reference adherence to “Timely Care Delivery Policy”

### Medical Records Policy and Procedures

#### Medical Records Use/Access

- Unique Identifiers, Storage and HER authentication

#### Information Governance Process or Procedure

- Appeals/Amendments process
- Must be approve by governing body

### Job Description Updates and/or HR policies or Clinical “Training” policies for:

- Administrator/designee
- DPCS/designee
- Medical Directors/designee

### Admission to Hospice

### QAPI Data Elements

### Governing Body Responsibilities/Requirements

### Care Coordination

- IDT Communication “formal” standards
- Reportable conditions/Changes that MUST be reported by staff and volunteers

### Timely Care:

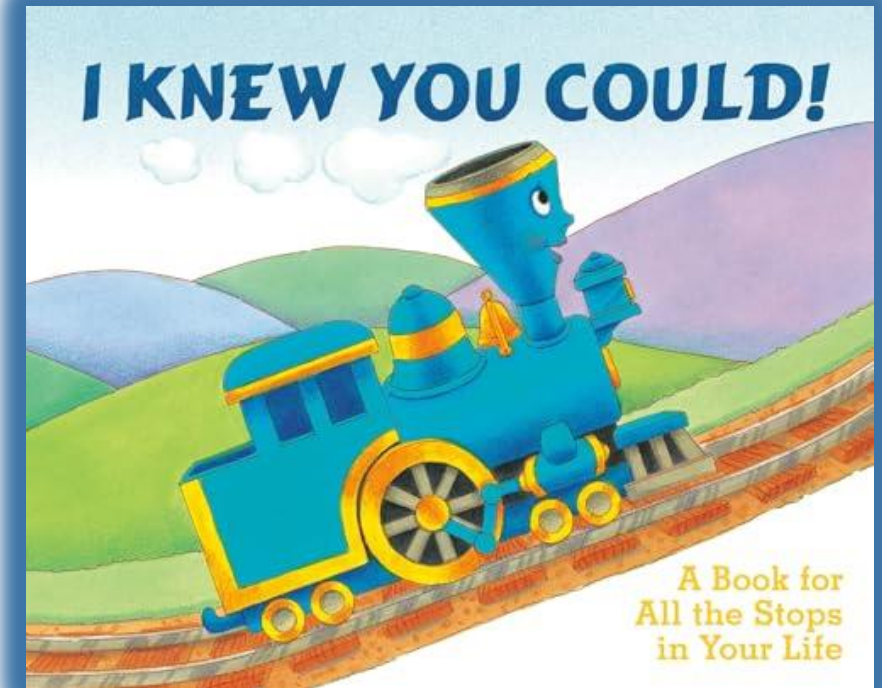
- Previously referenced in Geographic Area slides



# Compliance and Quality "Key" KPIs

- Compliance KPIs:

- SSVI Items
- HCI Items
- HVLDL Procedures and outcomes
- Long LOS Review Procedures (% ALZ?) and outcomes
- Coding Procedures (HNP/Related vs. Un-related)
- CTI's (related vs. Un-related)
- Adverse Events
- Field Surveillance Visits (Anything you want to monitor! + Survey Readiness)
- DC Chart Reviews (Survey Readiness: VF's, HHA SUP, 3rd benefit period eligibility, IDG)
- Volunteer Program (retention, roster, cost savings)
- Performance Improvement Plans ("PIP's)
- Customer Service" key Questions"
  - Timely Care
  - Help for Pain and Symptoms
  - Likelihood of recommendation
  - Overall Rating



# Compliance KPIs-Customer Service Key Questions

## Hospice Customer Service

Hospice: Treating Patients with Respect and Care Preference

*Never, Sometimes, Usually, ALWAYS*

10. How Often did the Hospice Team treat your family member with DIGNITY and RESPECT?

11. How often did you feel that the hospice team REALLY CARED about your family member?

*Yes, somewhat vs. Yes, Definitely*

12. Did the Hospice Team Provide Care that Respected your family members wishes?

13. Did the Hospice Team MAKE AN EFFORT to listen to the things that mattered most to your or your family member?

24. Did the Hospice team teach you how to care for your family member?



# From orientation to handbook to patient discharge and satisfaction

- The orientation and knowledge to thrive in hospice is laid out in the certification process
- Understanding the regulatory intent adds consistency in your agency and become the way you act – compliant, knowledgeable, able to problem solve without the referral source wondering – you become the source.
- Referral sources see the confidence; the confidence all staff have learning the same thing!!!
- You become recognized as knowing what you are doing-when the referral source talks with patient/family you are praised.
- When your liaisons go to a referral source they have accurate UP TO DATE clinical info and can answer any eligibility questions
- Performance evaluations reflect understanding the regulations—an agency wide performance metric
- You will build on survey findings and learn from current enforcement



# Will this increase my ratings, my scores?

## Yes! Everyone thinks alike.

- Even with hospice experience, anyone joining your agency must have a dedicated number of hours of onboarding and orientation as required by CDPH
- Yes, you will build your library of education, but all hospice agencies must provide the education from the outline presented in the regulations of Title 22
- Hard work? Yes,
- Increased retention? –Yes
- Increased patient /family satisfaction, Yes! as everyone has the same information –saying the same thing!!!
- Decreased survey apprehension? Yes—education, your matrix of completing education is demonstrated
- National data analysis increases? Yes-leadership direction drives the orientation



# Hints to find the time and demonstrate compliance with the regulations?

- Attend the conference—take notes and prioritize where to begin
- Return to the agency and schedule consistent meetings, with all departments present, to understand the regs
- Turn the change of regulations into a PIP!!! Track readiness and track improvement after education
- Review your last actual or mock survey—where are most of your deficiencies?
- Choose leaders, including clinicians, to provide the best education you already have and fill in the blanks
- Start with a SWOT of your current onboarding and education and priority the risks, set goals for the top deficient areas to be resolved—split up the work to someone that knows best, involve all departments, including marketing—they must know the regs!
- Bring data that you currently have as a baseline—example –from intake—time from inquire to insurance verification to scheduling to admission and all disciplines at the 5-day report
- Obtain information from your EMR vendor and be involved in updates—IT can educate clinicians



# Communication, communication, tracking metrics, communication

## Who, what, when, where should I think about concerns?

- EMR: Anticipate monthly education updates and involve your EMR vendor to ensure forms are up to date for the monthly updates to share with staff of where/how to document! Consistency!!!
- Audit to track improvement or next steps: Anticipate increased, specific audits from clinical records to billing to marketing material updates
- Save time in audits: Present examples to department teams, where to look to find the change in the clinical record, etc.
- Vendors: Ensure outside vendors are very aware of the education you are providing and expectations of compliance—if you outsource—how do you know they are keeping up with the Federal and state changes?
- Coders: Audit your vendors , such as coders, QA reviewers, have available someone in leadership to answer questions on the HOPE tool, a question on the referral of eligibility
- Communicate frequently –schedule specific times with vendors-even for 15 minutes



## Know your resources and schedule weekly time to read/catch up/pass on/implement

- CAHSAH hospice committee will have the latest and greatest info-quarterly meetings, network!
  - Your Accrediting Organization will be providing new standards with the Federal regs
  - CDPH will be putting out information
  - AFL (All Facilities Letters) may provide updates
  - Your MAC will be adding Federal issues to their website
  - Assign someone to track changes for 2-4 hours weekly and then who will need to know and urgency of the info!
    - Feds, state, Policies and Procedures
  - If you are hospital based-include your hospital QA team—they may see something you missed
  - MLN
- OTHER resources to SHARE???

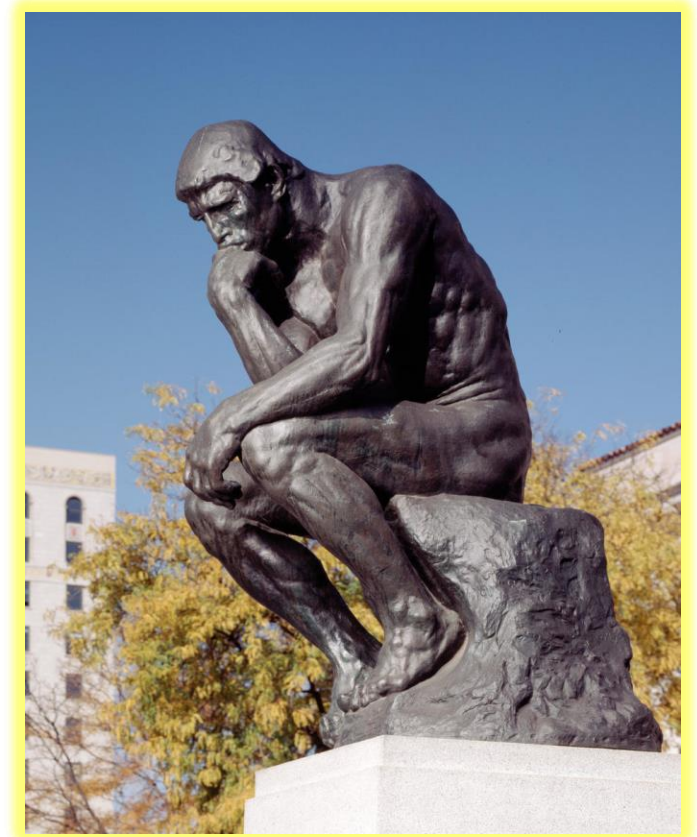


# Opportunities to Thrive

**Really ?**

Understand CMS and who is involved?

What to do now.....



# OIG: US Dept. of Health and Human Services

- Immediate Office of Inspector General (IO)
- Office of Counsel to the Inspector General (OCIG)
- Office of Investigations (OI)
- Office of Audit Services (OAS)
- Office of Evaluation and Inspections (OEI)
- Office and Management and Policy (OMP)

## **Publication of the OIG Compliance Program Guidance for Home Health Agencies**

Federal Register / Vol. 63, No. 152 / Friday, August 7, 1998 / page 42410 / Notices

bottom left corner page 42410 is titled

Office of Inspector General reports to DHHS

# California Hospice Licensure and Oversight



## FEDERAL

### Centers for Medicare & Medicaid Services

- Administers the Medicare and Medicaid programs at the federal level.
- Certifies hospice agencies to receive payment from Medicare.

### U.S. Department of Health and Human Services Office of Inspector General *and*

### U.S. Department of Justice

- Investigate Medicare fraud.



## ACCREDITORS

- Perform certification/recertification for Medicare.
- Perform licensing initial site visits as part of Medicare certification.



## STATE

### California Department of Public Health

- Licenses hospice agencies in California.
- May perform inspections to ensure compliance with requirements.
- Investigates complaints.
- Receives reports from mandated reporters regarding elder abuse in certain long-term care facilities.

### *Contracting with*

### County of Los Angeles Public Health

- Contracted by California Department of Public Health to perform licensing and certification services in Los Angeles County.

### California Department of Justice Office of the Attorney General

- Investigates and prosecutes Medi-Cal provider fraud, as well as abuse or neglect of patients in health care facilities receiving Medi-Cal payments.

### California Department of Health Care Services

- Determines Medi-Cal eligibility of patients.
- Processes Medi-Cal payments.
- Investigates suspected Medi-Cal fraud.

### California Department of Social Services

- Licenses residential care facilities for the elderly, which can house patients who are receiving hospice care.
- Receives reports from mandated reporters regarding elder abuse occurring in residential care facilities.
- Assists counties in the operation of their adult protective services programs, which may receive complaints from mandated reporters for elder abuse occurring outside long-term care facilities.

Source: Federal and state law, CMS *State Operations Manual*, OIG website, U.S. Department of Justice website, and Public Health and Los Angeles County's licensing and certification contract.

# The Big Picture



## Manuals/Websites Compliance, QAPI, Education

- Benefits: Hospice= Ch 9; HH=Ch 7
- SOM:; Appendix M=Hospice; Appendix B=HH. Available from CAHSAH
- Program Integrity Manual CMS (revised 01-22-26)
- Compliance Plan in your P&P-(may need revision-Hotline) educate
- Hospice Fraud Prevention Website <https://www.hospicefraudprevention.com>
- CMS SOM Chapter 2 - The Certification Process
  - Provides info on application processes and voluntary terminations of licensure- (last update 0624 (watch for changes )

## CA Health & Safety Codes drive the proposed hospice T 22

- (HSC § 1747-1759)
- Hospice Billing regulations: Chapter 11
  - [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf)
- Home Health Billing regulations: Chapter 10
  - [www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c11.pdf](http://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c11.pdf)



# Get your agency in order-thrive with leaders

- Operations and process flows will change quickly
- P&P manuals will need updated overnight
- Keep your Governing Body informed
- Your team and Medical Director must know what is going on
- Stop the rumors-voice mails-emails from management
- Expect overnight changes
- This is your new PIP—assign leaders
  - Who is watching and listening to changes;
  - Get active in CAHSAH and national committees
- Claims are the target-keep documentation and claims clean!!!!



# CAHSAH      E-Alerts      May 13, 2026

## **CMS Implements Temporary Nationwide Home Health and Hospice Moratorium**

**What Providers Should Do Now:** CAHSAH strongly encourages providers to immediately:

- Review and update their Compliance Program Plan
- Conduct internal reviews of billing and claims practices
- Ensure documentation supports medical necessity and eligibility requirements
- Evaluate any outlier utilization or billing trends that could trigger scrutiny
- Closely monitor CMS program integrity guidance and enforcement activity

# Proposed changes-how compliant are u now?

Risk areas: eligibility established during referral process

- Timely with everything
- Signatures are legible or attestation; EOB forms are filled out completely
- Hospice addendum to all patients and with any plan of care
  - What are your current processes and checks for patient response
  - HOVs—do the meds match the profile (clinical care) and compliance do they match the addendum (\$)
- HQRP, Care Compare and statistical data -are you using frequently?
- Reporting to the Governing Body changes and actions
- Expect the current reasons to increase –CMS will have data before u
  - LOS, weekend visits, continuous care, utilization of disciplines, IDG
  - Any weak areas you have now-it may be too late to correct, but get the plans into your compliance program-STAT-
  - Skin substitutes-expect charts to be reviewed!
- Care Compare with increased CMS data collection-watch your ratings

# Must integrate Compliance, QAPI, P&Ps, Educate

We have identified several areas today and things to do

- ID your risks, and prioritize them-involve your compliance officer and the plan
- Know the regulations, SSVI, educate often, update your employee handbook
- Audit: eligibility, F2F, orders, documentation pre-claim billing audits
- Audit timeliness: documentation submission, QAPI and compliance reports to Board
- Know your team and who can assist with audits! Know your consultants!



# Headlines & consumer complaints/concerns

- •Let's talk the complaint/incidents.....
- •Consumers have a hotline to call, as do you
- •However, if anyone thinks you are fraudulent and calls the hotline, anticipate you will be visited, audited, etc.
- •How often do you hear someone say—way too many supplies; patient continues to refuse to follow physician orders.....
- •They said no one has visited for a month—what to do? Report to leadership, leadership to investigate for compliance- alternative? Wait for OIG/DOJ to investigate the agency. Always think compliance!!!!



# Reporting fraud –the consumer

- <https://www.cms.gov/training-education/partner-outreach-resources/partner-with-cms/fraud-prevention-toolkit>
- <https://www.cms.gov/files/document/medicarehospicefraudpreventionoutreachtoolkit2024.pdf> (English and Spanish)
  - To learn more, visit Medicare.gov/fraud. To report potential fraud, call 1-800-MEDICARE (1-800-633-4227). Information provided by the U.S. Department of Health & Human Services.
- <https://smpresource.org/mfpw-event/medicare-fraud-prevention-week-nh/>



# Education & Reporting fraud-the professional

- Education: <https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/compliance-201-for-health-care-providers/content/#/>, for trainings on FWA and enhance your compliance plan and training for the Board, also Basic understanding (7 Elements) Tools, Roadmaps
- Report fraud: <https://oig.hhs.gov/fraud/report-fraud/identity/>
- Prepare before you submit: <https://oig.hhs.gov/fraud/report-fraud/before-you-submit.asp>.
- **File the complaint**
- • Online at <https://tips.oig.hhs.gov/> • By Telephone at: 1-800-HHS-TIPS (1-800-447-8477) • By Fax at: 1-800-223-8164 • By TTY at: 1-800-377-4950 • CMS Fraud,



# Education for FWA

- [oig.hhs.gov/aian](https://oig.hhs.gov/aian), for trainings on these topics.
- Report it: <https://oig.hhs.gov/fraud/report-fraud/identity/>
- 
- Be prepared: <https://oig.hhs.gov/fraud/report-fraud/before-you-submit.asp>.
- 
- **File the complaint**
- You can file a complaint in the following ways.
  - Online at <https://tips.oig.hhs.gov/>
  - By Telephone at: 1-800-HHS-TIPS (1-800-447-8477)
  - By Fax at: 1-800-223-8164
  - By TTY at: 1-800-377-4950
- CMS Fraud,



# CoP 484.100 : Compliance with laws and regulations

- Noncompliance with this condition includes:
  - 1) Agency is not currently licensed per State requirements
  - 2) Agency has been cited by Federal programs (other than CMS), or a State or local authority for a noncompliance with licensing requirements. The Federal, state or local authority has made a final determination, after all administrative procedures have been completed; all appeals have been finalized; and the findings of the noncompliance with the laws/regulations were upheld and enforced.



# Suspended, License Revoked, SA surveys

- SA=State Agency=CDPH
- If you are suspected of Fraudulent Conduct, CMS has the right to pull your deemed status.
  - Meaning: you are no longer certified through an accrediting organization
  - You have lost your accreditation and you are now certified with CDPH
  - You know longer can reach out to your accrediting organization

You will be surveyed by CDPH



# Can you appeal revocation?

- You have lost any billing privileges...
- •42 CFR Part 498 to administratively appeal a denial of billing privileges based on the imposition of a temporary moratorium
- •T 22 74687 Reinstatement of Revoked or Suspended Licensure
- **currently** states “after a period of not less than a year has elapsed from the effective date of the decision.....pursuant to Government Code Section 11522
- CFR: Code of Federal Regulations U.S. Law Title 42 is Public Health
- eCFR: the *Code of Federal Regulations* (CFR) is the official legal print publication containing the codification of the general and permanent rules published in the *Federal Register* by the departments and agencies of the Federal Government. The Electronic Code of Federal Regulations (eCFR) is a continuously updated online version of the CFR. It is not an official legal edition of the CFR



# Voluntary Suspension of License T22 Article 2, License 2025

## **§74679. Voluntary Suspension of License**

- (a) A licensee may request in writing that a license be put in suspense. The Department may approve the request for a period not to exceed 12 months.
- (b) Any license which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active license, including the payment of license renewal fees, during the period of temporary suspension.
- (c) Any license suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension, on receipt of an application and evidence showing compliance with licensing operational requirements in effect at the time of reinstatement. If license is not reinstated within the 12-month period, the license shall expire automatically and shall not be subject to reinstatement.

## **§74681. Voluntary Cancellation of License**

- (a) Any licensee desiring to voluntarily surrender a license for cancellation shall notify the Department in writing as soon as possible.
- (b) Any license voluntarily canceled pursuant to this section, may be reinstated by the Department within 12 months of the date of cancellation on receipt of an application and evidence showing compliance with licensing operational requirements.



# Revocation or Involuntary License Suspension

## **T 22 §74683. Revocation or Involuntary Suspension of License**

**(a) Pursuant to proceedings conducted under the provisions of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code beginning with Section 11500, the Department may suspend or revoke the license of any agency upon any of the following grounds:**

- (1) Violation by the licensee of any of the provisions of Chapter 8 of Division 2 of the H&S Codes beginning with Section 1725 or of any of the regulations promulgated by the Depart contained in Chapter 6 of Division 5 of Title 22 of the California Administrative Code ((which are standards of a licensed agency –cited in T22))**
- (2) Aiding, abetting or permitting the commission of any illegal act.**
- (3) Misrepresentation of a material fact in the application for a license.**
- (4) Failure to report any changes required by Section 74661-Application for license**
- (5) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the provision of services.**



# Be ready ! Anticipate audits and on-site visits

- Build QAPI thinking compliance as the goal
- Match CMS audits: review last two (2) nursing notes in your live discharges and the reasons for live discharge are clearly documented; hospitalizations returning to same hospice
- Utilization data: w/e visits, SN patient time, continuous care; LOS
- Alzheimer's diagnosis benefit double from 2021-2025 to 22% (CA increased 20%)
- Skin substitutes-and partnerships
- Outside spending \$



# Moratoria will end.....TBD

- Increased review and wait time with CHOWs
- In the enrollment process? Application must have been received prior to May 13<sup>th</sup> 2026
  - Take this gift—even more time to ready for your survey
- Understand all the regs, including building your compliance plan
- Use the knowledge and tools from the presentation today and the conference
- Prioritize as you return to the office
- LISTEN and celebrate the good and great things



# Questions??



Hospice: A new Day has dawned!



# THANKYOU!

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