Summary of Key Changes of APL 25-008 vs 13-014

APL 25-008 (May 5 2025) keeps the core hospice rules from APL 13-014 (Oct 28 2013) but layers on-top a series of new, sharper compliance, documentation and payment requirements. The main additions you'll need to bake into plan policies are below (each bullet highlights what is *new or materially expanded* in the 2025 letter).

Theme	What's new in APL 25-008 (vs. 13-014)
1. Faster, paper-trail-driven eligibility	*Election notice & liability*: hospice provider must submit DHCS "Medi-Cal Hospice Program Election Notice" **within 5 calendar days** or eat the cost of days prior to submission; plans may deny/recoup if documentation doesn't support medical necessity
2. Out-of-network hospice & continuity-of-care	Plans are told to get a single-case/LOA when members pick an out-of-network hospice and verify Medicare certification, CDPH license & NPI **before paying claims**. Plans must spell out a process to get members served "timely" while paperwork is pending
3. Face-to-face encounter rule	Starting the 3rd benefit period, a hospice MD/NP must conduct (and attest to) an in-person exam 30 days before the period (or 2 days after admission if late), then before every subsequent period
4. More granular payment logic	• New revenue-code set (0650/0652/0655/0656/0659 + 0552 add-on) replaces Z-codes. • Distinct **high (days 1-60)** vs. **low (day 61+)** routine home-care rates, with automatic reset after a 60-day hospice gap. • Service-intensity add-on for last 7 days of life. • Clarifies inpatient-vs-home-care payment on discharge-day and resets after readmission
5. Fraud, Waste & Abuse (FWA) controls	Entirely new section directing plans to flag hospice members in systems, scrutinise documentation, submit complete encounter data, and be ready for DHCS audits; non-compliance can trigger CAPs and monetary sanctions
6. Children / CCS integration	Builds on 2013 language but now ties directly to EPSDT, CCS Whole Child Model and concurrent palliative–curative care, with cross-references to newer CCS numbered letters

7. Provider-plan administrative duties	• Plans must update P&Ps or file a “no-change” attestation in the MCOD portal **within 90 days**. • Must flow requirements to all subcontractors/downstream entities
8. Benefit-period restatement	25-008 re-states the Medicare two-90-day + unlimited-60-day structure up-front for clarity
9. Documentation-driven utilisation review	Still no prior authorization for home-care levels, but plans may down-code/pay if post-service docs don’t justify higher levels, with appeal pathway spelled out

In short: APL 25-008 keeps the substantive hospice benefit intact but converts what were largely policy descriptions in 2013 into enforceable **process steps, documentation deadlines, revenue-code logic and FWA safeguards**. Plans need to update internal workflows, provider manuals and claims edits accordingly.