DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

RULEMAKING FILE

(Hospital Fair Billing Program)

Item 11:

FINAL STATEMENT OF REASONS

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FINAL STATEMENT OF REASONS

UPDATE OF INITIAL STATEMENT OF REASONS

As authorized by Government Code section 11346.9, subdivision (d), the Department of Health Care Access and Information (Department) hereby incorporates the Initial Statement of Reasons (ISOR) prepared in this matter. Unless specifically discussed otherwise below, the ISOR's stated bases for the necessity of the proposed regulations continue to apply to the regulations adopted.

All modifications from the initial proposed text of the regulations are summarized below. All references to the regulations are to Title 22 of the California Code of Regulations.

Changes Made to Article 1. Definitions; Document Accessibility; Eligibility Letters; Hospital Bill Complaint Program Notice; and Hospital Delegation

The title of Article 1 has been modified to add the term "determination," so it now reads, "Definitions; Document Accessibility, Eligibility Determination Letters; Hospital Bill Complaint Program Notice; and Hospital Delegation." This change is necessary to make the language used in this title consistent with the language used in the title of Section 96051.2.

A. 22 CCR § 96051. Definitions

Subsection (b) has been modified to clarify the definition of "charity care" to mean both free health services provided without expectation of payment and free or reduced cost health services provided to patients who qualify under a hospital's charity care policy. This change was made in response to comments expressing confusion about the proposed language compared to both industry practice and the definition of "charity care" under Health and Safety Code section 127345 (a). This is necessary to clarify that the definition of "charity care" under Health and Safety Code section 127345 (a) is one of two definitions of the term "charity care," but that hospitals may choose to offer reduced cost health services to eligible patients as a form of charity care in addition to free health services provided without expectation of payment.

Subsection (d) was added to provide a definition of "discount payment." This change was made in response to comments expressing confusion about the proposed definition of "charity care" and whether that definition conflated "charity care" and "discount payment." This is necessary to clearly distinguish "discount payment" from "charity

care," which are distinct programs subject to different statutory and regulatory requirements.

Subsection (e) was formerly subsection (d) and has been renumbered.

Subsection (f) was formerly subsection (e) and has been renumbered.

B. 22 CCR § 96051.1. Document Accessibility

Subsection (a) has been modified to add language that all documents made available to the patient must comply with the accessibility standards set forth in this section. The original proposed text set forth the requirement that all documents provided to the patient under the Act comply with the accessibility requirements. The modification, adding the term "or made available," clarifies that all documents available fora patient's viewing under the Act must comply with the standards; not only the documents actually or physically provided. This is necessary to ensure that all documents that will be viewed by a patient, including but not limited to those available online, such as the policies and list of shoppable services, or posted on hospital walls, are also subject to the accessibility requirements.

Subsections (a)(4) and (a)(5), which required hospitals documents to include information on disability and language access, have been removed and replaced with subsection (b), which is discussed in greater detail below.

Subsection (a)(4) was formerly subsection (a)(6) and has been renumbered.

Subsection (b) has been added to require all notices provided under section 96051.2, Health and Safety Code section 127410 (a), and Health and Safety Code section 127425 (e) include a tagline sheet in the top 15 languages spoken by limited-English-proficient individuals in California, as determined by the State Department of Health Care Services. Subsection (b) provides the specific language that shall be included in the notices, which includes information on where patients may obtain more information in their language and/or access their documents in accessible formats such as braille, large print, or audio. This is necessary to ensure the largest number of patients receive meaningful notice about the Hospital Bill Complaint Program, while balancing the burden to hospitals.

The note section has been modified to add Health and Safety Code sections 127405, 127425, and 127430 as reference citations. This is necessary because the requirements of section 96051.1 apply to hospital documents and notices provided or made available to patients under Health and Safety Code sections 127405, 127425, and 127430.

C. 22 CCR § 96051.2. Eligibility Letters

Section 96051.2 has been modified to add the term "determination" to the title, to now read as "Eligibility Determination Letters" instead of "Eligibility Letters." This is necessary to clarify that this section pertains to letters that hospitals provide patients

who applied to the discount payment or charity care program and include information on whether the patient was approved for financial assistance, versus a letter about general eligibility.

Subsection (a) has been modified to add the term “program” after “discount payment” and “charity care.” This is necessary to clarify this subsection refers to the discount payment and charity care programs, not the discount payment or charity care policies or a discounted payment made to the hospital.

Subsection (a)(1) has been modified to add that a patient eligibility determination letter must include the hospital’s determination of the patient’s eligibility, specifically for the discount payment program and/or the charity care program. This change was made in response to a comment requesting clarity around what “patient eligibility” specifically referred to. This change is necessary to clarify that the hospital’s eligibility determination letter must state whether the patient was approved or denied for any financial assistance program(s) the patient applied for, whether that be the discount payment program, the charity care program, or both.

Subsection (a)(2) has been modified to add the term “eligibility for.” This is necessary to clarify if a patient was found ineligible for the discount payment and/or charity care program, the patient’s eligibility determination letter must include a clear statement explaining why the patient was denied.

Changes Made to Article 2. Submission of Discount Payment, Charity Care, and Debt Collection Policies and Procedures

The title of Article 2 has been modified to remove “submission of” from the beginning of the title, so it now reads, “Discount Payment, Charity Care, and Debt Collection Policies and Procedures.” This change is necessary because, in addition to the submission of discount payment, charity care, and debt collection policies and procedures, Article 2 also addresses policy requirements, document requirements, and information on the policy review process.

A. 22 CCR § 96051.6. Hospital Policies

Subsection (a)(2) has been modified to clarify that the discount payment policy and the charity care policy are two distinct policies that both must include eligibility procedures and the hospital’s review processes. This was done by including the term “policies” after “discount payment,” making the term “the hospital’s review processes” plural and adding the term “in accordance with the Act.” These changes were made in response to comment that the proposed regulations did not make clear that hospitals are required to submit both a discount payment policy and a charity care policy. Although the Act is clear that both a discount payment policy and a charity care policy must be submitted to the Department, comments suggested that the regulations were less clear. Therefore, the changes were made to clarify that both a discount payment policy ***and*** a charity care policy must meet the outlined requirements.

Subsection (a)(2) has also been modified to clarify that the policies submitted to the Department must include eligibility procedures and review processes that are in compliance with the Act. This change was made in response to a comment that subsection (a)(2) be modified to list the section of the Act that sets forth the eligibility and review process requirements. Because the entire Act relates to the hospitals' obligations, the Department determined it was more appropriate to include the term "in accordance with the requirements outlined in the Act." This is necessary to clarify that all policies for the discount payment and charity care programs must comply with all requirements set forth in the Act.

Subsection (b)(2) has been modified stylistically, deleting the term "as utilized in" from the term "as utilized in this section," and replacing it with the term "for the purposes of this section." This change was necessary to maintain consistency throughout the text of the proposed regulation. Likewise, subsection (b)(5) was modified to add the term "for the purposes of" to the definition of "significant change." This change was necessary to maintain consistency throughout the text of the proposed regulation.

Subsection (d)(1) has been modified to allow hospitals 30 calendar days to respond to correspondence from the Department regarding hospital policies. This change was made in response to a comment that the initial proposed timeframe of 10 working days to respond was insufficient to allow hospitals to prepare written responses and submit revised policies, if applicable. This change is necessary to balance the intent of the Act with the burden on hospitals to provide accurate and comprehensive responses to correspondence from the Department regarding policies.

Subsection (d)(4) has been modified to replace "10 working days" with "30 calendar days." This change is necessary to make the language used in this subsection consistent with the language in Section 96051.6 (d)(1).

B. 22 CCR § 96051.7. Discount Payment Program

Subsection (a) has been modified to specify all medically necessary services are eligible for the discount payment program, unless the hospital obtains an attestation that the hospital services at issue in the complaint were not medically necessary from either the provider who referred the patient for the hospital services at issue in the complaint or the supervising health care provider for the hospital services at issue in the complaint. This change was made in response to a comment that stated the term "treating provider" is overly broad and may include providers who treated the patient for unrelated issues. Subsection (a) has additionally been modified to add the hospital shall obtain the required attestation before it may deny a patient's discount payment program application on the basis that the services at issue were not medically necessary. These changes are necessary to clarify what constitutes a valid attestation; specifically, who may provide the attestation and that the attestation must be provided before the hospital may deny a patient eligibility for the discount payment program on the basis that the services at issue were not medically necessary.

Subsection (a)(1) was added to define “supervising health care provider” to mean the primary physician or, if there is no primary physician in the patient’s record, the health care provider who had primary responsibility for the patient’s health care. This is necessary to clarify the supervising health care provider refers to the primary physical who oversaw the patient’s hospital care for the dates of service at issue in their complaint.

Subsection (b) has been modified to add the terms “the” and “program.” This is necessary to clarify this subsection refers to the discount payment program, not the discount payment policy or a discounted payment made to the hospital.

Subsection (b) has been further modified to remove the term, “if the patient is utilizing paystubs to document income, the hospital may request a maximum of six months of consecutive paystubs.” This change was made in response to a comment stating the prior language may have prevented individuals who were unable to provide six months of paystubs from applying for the discount payment program. This is necessary so hospitals do not request six months of paystubs by default, which may create an unfair barrier.

C. 22 CCR § 96051.8. Applications for Eligibility for Discount Payment Program or Charity Care Program

The title of section 96051.8 has been modified to add the word “program” after “discount payment” and “charity care.” This is necessary to clarify this subsection refers to the discount payment and charity care programs, not the discount payment or charity care policies or a discounted payment made to the hospital.

Subsection (a)(1) has been modified to include “the hospital may accept other forms of documentation of income but shall not require such other forms.” This change is necessary to clarify that if a patient is unable to provide recent paystubs or income tax returns for documentation of income, the hospital is permitted to accept other forms of documentation of income. This is necessary because the intent of the Act is to limit eligibility for hospital discount payment programs to qualified patients, the intention is not to deny a patient’s application for the discount payment program if they are unable to provide recent paystubs or income tax returns for a valid reason, for example if the patient was recently out of work. The regulation also clarifies the hospital cannot require additional documentation from patients in order to determine the patient’s eligibility.

Changes Made to Article 3. Notice and Posting Requirements

A. 22 CCR § 96051.9. Discharge Notice

Subsection (b) has been modified to clarify that a contemporaneous record will suffice as sufficient proof that the hospital provided a patient with a written discharge notice. This change was made in response to a comment that stated it was unclear what may constitute as “proof” that a hospital provided the required written discharge notice to the patient. This change is necessary to clarify a contemporaneous record that the written

notice required under Health and Safety Code section 127410 (a) and (b) was provided to the patient and retained in accordance with the hospital's record retention requirements outlined in state and federal law will suffice as sufficient proof and fulfill the requirements under section 96051.9(b).

B. 22 CCR § 96051.10. Hospital Postings

Subsection (a)(1) has been modified to remove the minimum font size requirements for hospital postings. This change was made in response to a comment expressing concern that the minimum font size requirements would require multi-page posters and significant wall space. This change is necessary to balance the intent of the Act to provide notice to patients while also taking into consideration the burden to hospitals.

Subsection (b)(5) has been modified to remove the term "electronic formats that are accessible and may be read by a screen reader in a logical reading order" and add the term "other accessible electronic formats." This change is necessary to be consistent with the document accessibility information in section 96051.1(b).

Changes Made to Article 4. Hospital Bill Complaint Program

A. 22 CCR § 96051.13. Patient Complaint Portal

This section has been modified to correct the URL of the Hospital Bill Complaint Program's online patient complaint portal to HospitalBillComplaintProgram.hcai.ca.gov. This change is necessary to provide the correct URL for the Hospital Bill Complaint Program's online patient complaint portal.

B. 22 CCR § 96051.15. Release of Information

This section has been modified to remove references to an authorized representative signing a release of information on behalf of a patient during the complaint process. This change is in response to a comment which raised concerns that some authorized representatives as defined in Section 96051.14 may lack the legal authority to sign a release of information on behalf of a patient. This change is necessary to comply with existing health information privacy laws.

C. 22 CCR § 96051.16. Filing a Patient Complaint

Subsection (b) has been modified to remove the term "at minimum" and clarify which data elements listed in this subsection are optional or only required if the patient has the information available. This change was made in response to comments stating the required data elements are overly burdensome on the patients, may discourage eligible patients from applying for financial assistance, and that hospitals may already be in possession of the requested information. This is necessary to clarify a complaint will still be processed if the patient or their authorized representative do not provide all the information listed within this subsection. If an optional data element is not provided, the complaint will still be processed and investigated by the Department. The specific changes are explained in more detail below.

Subsection (b)(6) has been modified to add the term “if available.” This change was made in response to a comment stating some patients will be unable to provide a mailing address with their complaint. This is necessary to clarify a complaint will still be processed when address information is not provided.

Subsection (b)(7) has been modified to add the term “if available.” This is necessary to clarify a complaint will still be processed when a primary phone number is not provided.

Subsection (b)(10) has been modified to add the term “optional.” This is necessary to clarify a complaint will still be processed when a preferred language is not indicated.

Subsection (b)(13) has been modified so the patient’s health plan, insurance, government insurance program information, and any respective membership numbers are only required if the patient has that information available. This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide the requested health coverage information.

Subsection (b)(14) has been modified to add the term “and available.” This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide information or supporting documentation about processed and paid claims for hospital services in question.

Subsection (b)(15) has been modified to add the term “and available.” This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide information regarding any grievance(s) they may have filed with their health plan about a coverage denial.

Subsections (b)(17) through (b)(19) have been removed. These subsections requested a patient’s health plan, insurance, and government insurance program membership identification numbers, which are now included in subsection (b)(13). It is necessary to remove these sections to avoid requiring the collection of redundant data elements.

Former subsection (b)(20) has been renumbered and is now subsection (b)(17). This subsection has been modified to add the term “and available.” This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide the date they submitted their discount payment program and/or charity care program application to the hospital, as well as whether their application was approved or denied.

Former subsection (b)(21) has been renumbered and is now subsection (b)(18). This subsection has been modified to add the term “and available.” This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide the date they appealed the hospital’s denial of their discount payment program and/or charity care program application.

Former subsection (b)(22) has been renumbered and is now subsection (b)(19). This subsection has been modified to add the term “and available.” This is necessary to

clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide copies of their hospital notice(s) and billing statement(s).

Former subsection (b)(23) has been renumbered and is now subsection (b)(20). This subsection has been modified to add the term "and available." This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide a copy of proof of payment for any amount the patient paid to the hospital for the services in question.

Former subsection (b)(24) has been renumbered and is now subsection (b)(21). This subsection has been modified to add the term "and available." This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient if the patient is unable to provide the date the hospital sold their debt to collections or the date they were notified their bill was in jeopardy of being sent to collections.

Former subsection (b)(25) has been renumbered and is now subsection (b)(22). This subsection has been modified to add the term "and available." This is necessary to clarify a complaint will still be processed and investigated by the Department if the patient is unable to provide documentation that their hospital debt was reported to a credit bureau and their credit/report score was impacted.

D. 22 CCR § 96051.17. Complaint Review

Subsection (a) has been modified to state that a patient or authorized representative must have submitted an application for discount payment and/or charity care to the hospital before HCAI will investigate an eligibility determination by the hospital. This change is in response to comments that the initial proposed language improperly limited review of patient complaints to only those cases where a patient or authorized representative has already submitted a discount payment and/or charity care application to the hospital. This change is necessary to clarify that HCAI will only review complaints regarding discount payment and/or charity care eligibility determinations if a patient or authorized representative has already submitted an application to the hospital. However, a patient or authorized representative may file a complaint regarding other possible violations without applying for discount payment and/or charity care in order for the complaint to be reviewed by HCAI.

Subsection (b)(1) has been modified to allow hospitals 30 calendar days to respond to patient complaints. This change was made in response to a comment that the initial proposed timeframe of 10 working days to respond was insufficient to allow hospitals to prepare written responses and submit copies of all relevant documents and information related to the issues raised in the complaint. This change is necessary to balance the intent of the Act with the burden on hospitals to provide accurate and comprehensive responses and records to HCAI regarding patient complaints.

Subsection (d)(1) has been modified to allow patients and hospitals 30 calendar days to respond to any requests from HCAI for additional information or records during the

complaint investigation. This change is necessary to make the language used in this subsection consistent with the language in Section 96051.17 (b)(1).

E. 22 CCR § 96051.18. Request for Extension

Subsection (a)(1) has been modified to replace "10 working days" with "30 calendar days." This change is necessary to make the language used in this subsection consistent with the language in Sections 96051.17 (b)(1) and (d)(1).

F. 22 CCR § 96051.19. Debt Collection Ceased While Complaint Pending

The title of this section has been modified to remove the term "ceased," so it now reads "Debt Collection While Complaint Pending." This change is necessary to make the language used in this title consistent with the meaning of the language used in this section.

This section has been modified to state that a hospital shall not send a patient's unpaid bill to collections once the hospital has been notified that the patient has filed a complaint with the Department, unless the assignee has agreed to comply with the Act. This change is in response to a comment stating the initial proposed language was overly broad and exceeded the Department's statutory authority. This change is necessary to narrow the scope of this section to be more in line with the language of Health and Safety Code Section 127425 (g).

The note section has been modified to add Health and Safety Code section 127425 as a reference citation. This change is necessary to fully capture all of the sections that are being implemented, interpreted, and made specific.

Changes Made to Article 5. Penalties

A. 22 CCR § 96051.21. Penalties for Late Filing of Documents and Responses

Subdivision (a) has been modified to reduce the amount of the penalty from $1,000 per day to $500 per day for a failure to timely file required discount payment, charity care, and debt collection policies and applications, and for a failure to timely respond to inquiries from the Department. Subdivision (b) has been modified to reduce the amount of the penalty from $1,000 per day to $500 per day for a failure to submit a requested response during an investigation of a patient's complaint regarding the requirements outlined in the Act, and this chapter.

The Department received comment that the proposed penalties for late filing of policies and applications had the potential of being disproportionate to the severity of the violation, noting an example of a hospital inadvertently failed to submit a notification to the Department that it had no changes to its policy and was not notified for two years. The hospital would be subject to a $730,000 penalty. The commentor noted that such a significant penalty would be disproportionate to other types of penalties. As an example, the commentor highlighted penalties resulting from the hospital failing to comply with the law regarding a patient complaint, which are capped at $40,000, or if a hospital had an

adverse event that results in the death or serious injury, where the penalties are capped at $75,000 for a first offense.

Under the previous statute, the Department was tasked with collecting policies and procedures for discount payment programs and charity programs and posting the documents to its website without review. The Act added a requirement that the Department review the policies and procedures for compliance with the Act. The new Department policy submission portal (HDC) will show the status of any submitted document. Additionally, Hospitals will be able to view the documents that were submitted. Given the Department's role in review policies and procedures for compliance and the new system, it is highly unlikely that the failure to submit a policy or procedure would go undetected for two years. Additionally, if a hospital has concerns that the document it submitted was not received by the Department, the hospital can contact the department for confirmation of receipt.

However, the concerns regarding the amount of penalty were noted and the amount of the penalty was reevaluated. The Department previously reviewed and addressed in the original Statement of Reasons the penalty structure for late filing of documents in other Department programs, noting that $1,000 per day is the penalty amount for late filings with regard to the Drug Transparency Act, pursuant to HSC section 127681 (f). However, upon further review, the Department also noted that the Department administers a Health Facility Data program that requires annual reports from each hospital. Under HSC 128770, the penalty for late reports accrues at a rate of $100 per day.

Therefore, a substantive change was made to this section to reduce the rate from $1,000 per day to $500 per day for late filings. The purpose of a penalty for late filing and late responses in these proposed regulations is to encourage hospital compliance and deter untimely filings and responses. The Department determined that a reduction of the fines from $1,000 per day to $500 per day is appropriate to best balance the need to encourage the hospitals' timely compliance while also taking into consideration the hospitals' financial stability.

B. 22 CCR § 96051.23. Penalty Assessment for Violations of Hospital Policy, Posting, and Website Requirements.

The title of this section has been modified to clarify its purpose by adding violations of "Postings, and Website" and to remove the term "Notice," so that it now reads, "Penalty Assessment for Violations of Hospital Policy, Posting, and Website Requirements." The change to the title of this section is necessary to more thoroughly and accurately capture the purpose of the section, which is to address penalties for violations of the Act or these regulations in relation to policies, postings and websites.

Subsection (a)(3) has been modified to more accurately capture the penalty structure of this section applies to all requirements of the website, by eliminating the word "posting."

This change is necessary to clarify the section applies to all website requirements set forth in the Act and these regulations and is not limited to website postings only.

Subsection (b)(2) has been modified to clarify the definition of moderate violations, by deleting the word “indirectly” before the word “impact.” The term now reads, “but has the potential to impact a patient’s ability to receive discount payment or charity care.” This change was made based on comment that the definition of a moderate violation was confusing. This change was necessary as it was determined the term “indirectly” was confusing and did not adequately capture the intent to define a moderate violation as a violation that did not directly impact a determination of a patient’s eligibility but had the potential to impact a patient’s ability to receive assistance through the discount payment program or the charity care program.

Subsection (b)(4) has been modified to eliminate the Department’s discretion to not assess a penalty in cases where the violation did not affect patient access to, or eligibility for, the discount payment program or the charity care program. This change was made in response to commentor’s request that in a situation where a violation that has no impact on patient access to, or eligibility for, the hospital’s discount payment or charity care program, and the hospital takes corrective action, the penalty should be zero and not be subject to the discretion of the Department. This change is necessary to provide the clearest possible penalty structure and to balance the intent of the Act to provide patients with meaningful access to financial assistance with the potential financial burden the penalty may impose on hospitals.

Subdivision (c) has been modified to clarify that this section does not apply to penalties arising out of the complaint process. Comments were made that expressed confusion regarding the original proposed text that excluded violations of HSC 127436. The intent of this subsection is to clarify that violations arising out of a patient complaint would not be processed under this section. This change is necessary because the original proposed text, referencing HSC 127436, was an error and created confusion. This change to, “Penalties for violations arising out of an investigation resulting from a complaint filed by a patient, as outlined in sections 96051.24, 96051.25, 96051.26, and 96051.27 shall be excluded from this section,” more clearly explains the penalty structure and process.

The note of section 96051.23 has been modified to add HSC 127436 as authority. This change is necessary to correct the error that HSC 127436 was previously not included as authority for this section. This is necessary to clarify that the authority to develop a penalty structure for violations of hospital policies, postings and websites arises from both HSC 127010 and 127436. As a result of the addition the word “Section” was modified to be made plural for grammatical purposes. Additionally, sections 127410 and 127436 of the HSC were also added to the Reference section. This modification was necessary to fully capture all of the sections that are being implemented, interpreted and made specific.

C. 22 CCR § 96051.24. Definition of Multiple Violations Identified During the Same Investigation, for the Purpose of Penalty Assessments.

Subsection (a) has been modified to clarify that the definition of an investigation applies to complaints arising out of the patient complaint process by adding (b) after Health and Safety Code 127436. This change is necessary to correct an error in the original proposed text. The intent of this section is to clarify what constitutes an investigation arising out of a single patient complaint. Referencing HSC 127436 (b) corrects this error.

D. 22 CCR § 96051.25. Determining the Base Penalty for Each Investigation Resulting in One or More Violation(s).

Subsection (a)(3) has been modified to indicate that there will be no penalty for a violation that did not affect the patient's access to, or eligibility for, the discount payment or charity care program, provided the hospital takes corrective action as directed by the Department. The modification has removed the Department's discretion in making the penalty zero. This modification was made in response to comment made regarding section 96051.23 (b)(4), requesting a de minimis category, for penalties for violations of policies, postings and websites. The Department accepted the comment, indicating that violations that did not have any impact on patient access to the programs or ability to qualify for the programs would receive no fine if the hospital took appropriate corrective action. Although the comment was directed to violations of postings, policies and websites, the correction is appropriate for the patient complaint process as well. This change is necessary to provide the clearest possible penalty structure and to balance the intent of the Act of providing patients with meaningful access to financial assistance with the potential financial burden the penalty may impose on hospitals.

E. 22 CCR § 96051.28. Failure to Reimburse Patient and Pay Assessed Penalty.

Subsection (a) was added to include language that, when a hospital determines that a patient paid an amount in excess of the amount required under the Act or these regulations, the hospital shall reimburse the patient within 30 days of the determination in accordance with HSC 127440. This modification is necessary to clarify that the hospital is not only obligated to make the payment when the Department makes the determination, as indicated in the previous text, but is also under an obligation to reimburse the patient within 30 days when the hospital discovers the violation without the assistance of the Department, in accordance with HSC 127440. Although this requirement is set forth in HSC 127440, this modification is necessary to extend the requirement that the hospital reimburse the patient with interest, within 30 days, when the hospital discovers a violation of the proposed regulations.

Subsection (b) was formerly subsection (a) and has been renumbered.

Subsection (c) was formerly subsection (b) and has been renumbered. This subsection sets forth the fines associated with a failure to timely repay a patient after the

Department has determined payment is owed. In the text of this subsection the term "A hospital that fails to reimburse the patient by the due date established by subsection (a)..." now reads, "A hospital that fails to reimburse the patient by the due date established by subsection (b)." This modification is necessary as a result of the renumber of subsection (a) to subsection (b).

Subsection (d) was formerly subsection (c) and has been renumbered. In the text of the subsection (d), the term "When the payment is made after the due date indicated in subsection (a), the Department will calculate the accrued penalty pursuant to subsection (b)," has been modified to read, "When the payment is made after the due date indicated in subsection (b), the Department will calculate the accrued penalty pursuant to subsection (c)." This modification is necessary as a result of the renumbering of subsection (a) to subsection (b).

Non-substantive, Grammatical, and Formatting Changes

- Title of Article 1 has been modified to delete the period at the end for consistency with other article title formatting.
- The note of section 96051.12 has been modified to make "Section," after Authority cited to be singular. This modification was made to correct a grammatical error as only one section was cited.
- Section 96051.16(b) has been modified to remove the comma after "shall." This change is necessary to correct a grammatical error.
- The note of section 96051.21 has been modified to add a comma after "Authority cited: Sections 127010 and 127436," which has been done for consistency throughout the text of the proposed regulations.
- The notes of sections 96051.23, 96051.24, 96051.25, 96051.26, 96051.27, 96051.28, 96051.29, 96051.30, 96051.34, 96051.35, 96051.36, 96051.37 have been modified to add the word "Section" or "Sections" in the reference portion, and a comma after the referenced section(s) which is done for consistency throughout the text of the proposed regulations.
- Section 96051.24(b) has been modified to add "a" before "single complaint." This change is necessary to correct a grammatical error.
- Section 96051.25 (a)(2) has been modified to add "and" after "twelve thousand." This change is necessary to correct a grammatical error.
- Section 96051.26 (a)(2)(C)(i) and (a)(4) have been modified to delete the term "Health and Safety Code section 127400 to 127446, inclusive," and instead reference "the Act." This change is necessary to make the language consistent with other references throughout these regulations.
- The note of section 96051.31 has been modified to add the word "Sections" in the reference portion, and to list out each section in the reference section, replacing the previous text, which indicated a range, Sections 127405 to 127436. These modifications are made for consistency throughout the text of the proposed regulation.

- The note of section 96051.32 has been modified to add a comma after the authority cited sections, to add the word “Section” in the reference portion, and a comma after the referenced section, which is done for consistency throughout the text of the proposed regulations and to correct a grammatical error.
- The note of section 96051.33 has been modified to make the word “Sections,” in relation to authority, plural. This modification is necessary to correct a grammatical error.

SUMMARY OF COMMENTS AND DEPARTMENT RESPONSES

The Department received three comment letters during the 45-day comment period and two comment letters during the 15-day comment period. The summary of the comments and the Department’s responses are attached as the following appendices:

> Appendix A. Summary and Response to Comments Submitted during 45-Day Period.
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> Appendix B. Summary and Response to Comments Submitted During 15-Day Period.

For ease of reference the Department assigned a number to each comment letter received. Because each comment letter contained multiple substantive comments that needed to be addressed, for each substantive comment, the Department assigned a comment number.

The “Summary and Response to Comments” appendices are organized according to the chronological order of the proposed regulations that they address. Comments relating to multiple sections of the regulations are grouped together at the beginning of each Article number. Comments generally about the regulations, but not regarding a particular section or subsection of the regulations, are grouped together at the end under the heading of “Other.”

LOCAL MANDATE DETERMINATION

The proposed regulations do not impose any mandate on local agencies or school districts.

ALTERNATIVE DETERMINATIONS

In accordance with Government Code section 11346.9, subdivision (a)(4), the Department has determined that no reasonable alternative it considered or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which the action is proposed, or would be as effective and less burdensome to affected private persons than the proposed action, or would be most cost-effective to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The final regulations represent a balanced approach that seeks to balance the burden to hospitals with the Act's purpose.

ALTERNATIVES THAT WOULD LESSEN ADVERSE ECONOMIC IMPACT ON SMALL BUSINESSES

There is no adverse impact on small businesses as none of the hospitals regulated by AB 1020 and these proposed regulations are small businesses.

ECONOMIC IMPACT ASSESSMENT/ANALYSIS

Modification to the proposed text of Section 96051.1 (b) requires that the notices required in CCR 96051.2 (Eligibility Determination Letter), HSC 127410 (a) (Discharge Notice), and HSC 127425 (e) (Goodbye Letter) include a tagline sheet with a statement provided in English and the top 15 languages spoken by limited English proficient (LEP) patients in California, explaining how to receive assistance. The translation of the information will be an estimated one-time cost and the cost of attaching the tagline sheet to the required notices is an estimated annual cost.

The average initial cost of translating the tagline sheet statewide will be $432,300, averaging $1,100 per hospital.

The original proposed regulation requires the Discharge Notice be provided in hard copy format. The modification to the proposed regulation requires the tagline sheet, when provided with the Discharge Notice, will also need to be in hard copy format. Once translated, to print and attach the tagline sheet will cost an estimated additional $1,714,970, statewide on an annual basis. The tagline sheet will be printed on two pages, one page printed 2-sided (at a cost of $0.018), and a second page printed single-sided (at a cost of $0.015). This would add an additional cost of $0.033 for the tagline sheet to be attached to the Discharge Letter. Using the data from the OSHPD 2019 Hospital Annual Financial Data Pivot Table (Pivot Table),[1] hospitals saw 51,968,811 patients. Multiplying the number of patients by $0.033, the estimated total cost for adding the tagline sheet to the hard copy Discharge Notice is $1,714,970.

The proposed modification to the regulations also requires a tagline sheet to accompany the Eligibility Determination Letter sent to any patient who applies for discount payment or charity care. There is no requirement that this letter or the tagline sheet be provided in hard copy format. Hospitals may choose to provide this letter electronically. However, if all hospitals elected to mail hard copy Eligibility Determination

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[1] 2021 Pivot Table – Hospital Annual Selected File (October 2022 Extract) https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/29bacfe7-a98d-4183-9282-a5803a3d4c6e?view_id=0e379425-1e60-4868-8064-d8d9a3c74e0a

Letters to patients, the Department estimates the additional annual cost of including the tagline sheet will be $13,245 statewide (.033 x 401,352 patients).

AB 1020 requires all hospitals send a Goodbye Letter to the patient prior to sending a bill to collections. The modification to the proposed regulation requires the tagline sheet to be included with the Goodbye Letter. The additional cost of the tagline sheet would be $0.033 per tagline sheet. Estimating 401,352 bills become bad debt and that all would receive a Goodbye Letter, the estimated additional annual cost of the tagline sheet requirement would be $13,245.

NON-DUPLICATION

Some of the regulations may repeat or rephase in whole or in part a state or federal statute or regulation. This was necessary to satisfy the clarity standard set forth in Government Code section 11349.1, subdivision (a)(3).

FSOR APPENDIX A: SUMMARY AND RESPONSE TO COMMENTS SUBMITTED DURING 45-DAY PERIOD

Response #	Summary of Comment	Response	Comment #s
CHAPTER 9. HOSPITAL CHARGES			
ARTICLE 2. HOSPITAL CHARGES AND FAIR PRICING POLICIES REPORTING			
§ 96042. Electronic Reporting of Hospital Discount Payment and Charity Care Policies, Eligibility Procedures, and Review Process			
1.	Comment requests section be amended rather than “undoing other regulations in a manner contrary to the statute.”	No change has been made in response to this comment. Section 96042 outlines procedures for submitting documents to the Department which will be outdated as of January 1, 2024. Where implementation of the statute is necessary by regulation, those requirements are being updated and moved to section 96051.6.	2-22
§ 96043. Electronic Reporting of Hospital Application Form for Charity Care or Discount Payment Programs			
2.	Comment requests section be amended rather than “undoing other regulations in a manner contrary to the statute.”	No change has been made in response to this comment. Section 96043 outlines procedures for submitting documents to the Department which will be outdated as of January 1, 2024. Where implementation of the statute is necessary by regulation, those requirements are being updated and moved to section 96051.6.	2-22

§ 96044. Reporting Significant Changes to Hospital Discount Payment and Charity Care Policies			
3.	Comment notes a preference for the new requirement in section 96051.6.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	2-23
§ 96050. Request for Modifications to Requirements			
4.	Health Access recognizes the need to update this section and provides comments below.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	2-24
CHAPTER 9.2: HOSPITAL FAIR BILLING PROGRAM			
ARTICLE 1. DEFINITIONS; DOCUMENT ACCESSIBILITY; ELIGIBILITY DETERMINATION LETTERS; HOSPITAL BILL COMPLAINT PROGRAM NOTICE; AND HOSPITAL DELEGATION			
§ 96051. Definitions			
5.	Opposes the characterization of discount payment as a subset of charity care, and states the Department's proposed definition of charity care contributes to a lack of clarity.	Accept in part. The Department agrees with the statement that discount payment is not a subset of charity care. This has always been the Department's position. In the initial proposed text, the definition for "charity care" included the term "discounted hospital care," which may have been a source of confusion. In response, the Department has added a definition for "discount payment" and revised	2-5

		the definition of “charity care” to provide additional clarity.	
6.	States that charity care is free care, contrary to the Department’s proposed definition of charity care which includes both free care and reduced cost care.	Accept in part. The Department agrees that while some charity care is free care as defined in HSC section 127345, the Department disagrees with the assertion that charity care is *only* free care. A hospital may elect to provide reduced cost services for patients who may not qualify for financial assistance under the hospital’s discount payment policy but who qualify for reduced cost services under the hospital’s charity care policy. The Department has revised the definition of “charity care” to include both free health services provided without expectation of payment and reduced cost health services or free health services provided to eligible patients as outlined in a hospital’s charity care policy.	2-5 3-15
7.	Proposes adding a definition for “discount payment.”	Accept in part. The Department has added a definition for the term “discount payment,” but did not use the definition proposed by the comment.	2-25
8.	Proposes revised definition of “charity care” to mean only free care, and the term “discounted” as used in the original proposed definition to mean a	Accept in part. The Department agrees that while some charity care is free care as defined in Health and Safety Code (HSC) section	2-26

	reduction in the charge beyond the 100% of Medicare or Medicaid rates as required by law.	127345, the Department disagrees with the assertion that charity care is *only* free care. A hospital may elect to provide reduced cost services for patients who may not qualify for financial assistance under the hospital's discount payment policy but who qualify for reduced cost services under the hospital's charity care policy. The Department has revised the definition of "charity care" to include both free health services provided without expectation of payment and reduced cost health services or free health services provided to eligible patients as outlined in a hospital's charity care policy. The revised definition has replaced the term "discounted" with "reduced cost" to provide additional clarity.	
9.	Proposes revised definition of "policies" to state that, if a hospital has a policy of providing free care, the hospital shall also submit a charity care policy.	No change has been made in response to this comment. This comment requests a revision that is contrary to the statute. See HSC section 127435 (a), which requires a hospital to provide the Department a copy of its charity care policy.	2-27
10.	Requests addition of definition for "uninsured patient."	No change has been made in response to this comment. Self-pay patient is defined in the Act as a patient who does not have third-	3-16

		party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Defining uninsured patient does not provide additional clarity and is unnecessary.	
§ 96051.1. Document Accessibility			
11.	Supports accessibility of documents in the proposed regulation.	The Department appreciates this comment of support. No change has been made in response to this comment.	2-1
12.	Supports the intent of the proposed regulation and recommends requirement that documents be written at third or fourth grade reading level. Additionally, suggests user-tested model notices that meet reading level requirements and are available in multiple translations for discount payment/charity care program applications and eligibility letters.	No change has been made in response to this comment. The comment's proposed change to require documents be written at third or fourth grade reading level is not more effective than the required plain and straightforward language in carrying out the purpose and intent of the Act. The Department is unable to address the issue of model notices at this time. To meet the January 1, 2024, deadline set forth by the Act, the Department prioritized the drafting of regulations that operationalize and assist in the immediate	2-28

		implementation of the law. Further analysis of this issue is required to determine whether a regulation regarding model notices is necessary.	
§ 96051.2. Eligibility Determination Letters			
- **§ 96051.2 (a)(1)**			
13.	Supports requirement that hospitals provide an eligibility determination letter including a clear statement on how the patient's eligibility was determined.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required. However, the Department modified this provision in response to another comment. See response #14.	1-1 2-2
14.	Requests additional language to specify the eligibility determination letter include the hospital's determination of the patient's eligibility "for the discount payment policy and/or the charity care policy."	Accept in part. The Department interprets this comment as a request to clarify the eligibility determination letter must include the hospital's decision on the patient's eligibility for the discount payment program and/or charity care program. Added "discount payment and/or charity care." See section 96051.2(a)(1).	2-29
§ 96051.4. Hospital Delegation			
15.	Revise to include assignees and buyers of debt and add if a hospital assigns or sells debt, the hospital does not waive the requirements of the Act and its corresponding regulations.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is	2-30

		unnecessary. See HSC section 127425.	
16.	Requests regulation be revised to require contracts between hospitals and debt collectors/debt buyers to contain provisions consistent with state law.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. See HSC section 127425 (c), which requires a hospital to establish a written policy defining standards and practices for the collection of debt and to obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. See also proposed 22 CCR section 96051.6 (3), which requires a hospital's debt collection policy to include the requirements outlined in HSC sections 127405 (e)(3), 127425, 127426, and 127430, in addition to all other applicable statutory and regulatory requirements.	2-18
ARTICLE 2. SUBMISSION OF DISCOUNT PAYMENT, CHARITY CARE, AND DEBT COLLECTION POLICIES AND PROCEDURES			
- **Article 2 generally**			
17.	Requests deletion of the words "submission of" in Article 2 title: "submission of discount payment, charity care, and debt collection policies and procedures" for clarity.	Accept. See Article 2 title.	2-31
§ 96051.5 Hospital Contact and Registration for Policy Submission			

18.	Supports section on hospital contact person.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response was required.	2-32
§ 96051.6. Hospital Policies			
- **§ 96051.6 (a)(2)**			
19.	Comment requests changes to Section 96051.6 to clarify that the discount payment policy is separate from the charity care policy and that hospitals are required to have a discount payment policy, but hospitals may or may not have a charity care policy.	Accept in part. The Department has modified the text of section 96051.6 (a)(2) to clarify that discount payment policies are separate from charity care policies. However, the comment that hospitals may or may not have a charity care policy is not consistent with the Act. HSC sections 127405(a)(1)(A) and 127435 (a) require hospitals to maintain and submit both a discount payment policy and a charity care policy.	2-21
20.	Comment requests specific provisions enumerated in the Act be restated in the proposed regulations. Comment notes that commentor has reviewed many policies and has yet to find a policy that commentor believes is consistent with the law.	No change has been made in response to this comment. The Department does not believe it is necessary or helpful to restate the requirements for discount payment and charity care that are set forth in	2-13

	Commentor notes the belief that the failure to comply is due to lack of oversight.	the Act. The Department interprets the commentor's note that hospitals' policies failure to comply is due to lack of oversight as an observation rather than an additional specific recommendation to change these regulations. The Department agrees that much of the problem has been a lack of oversight and believes that the authority granted to the Department beginning January 1, 2024, will rectify the lack of oversight issue.	
21.	Comment suggested specific language that the policies be consistent with the Act. The Comment proposed the following language, "The discount payment policy shall be consistent with the requirements in Health and Safety Code Sections 1274xx. The charity care policy, if any, shall be consistent with the requirements in Health and Safety Code Section 1274xx."	Accepted in part. The term "in accordance with the requirements outlined in the Act" has been added to the regulation. The Department did not use the language proposed by the commentor as it did not provide sufficient specificity for the Department to make the proposed modifications to the text.	2-33
- **§ 96051.6 (d)(1)**			
22.	States that 10-day time frame to respond to HCAI questions and to submit revised policies is too short and requests this be revised to 30 calendar days.	Accept. Section 96051.6 (d)(1) has been revised to allow hospitals 30 calendar days to respond to Department correspondence regarding policy submission and revisions.	3-1
- **§ 96051.6 (d)(5)**			

23.	States that, if the Department does not adopt the 30-calendar day timeframe proposed in comment 3-1, alternatively the Department could create a process for hospitals to request and receive an automatic extension based on the complexity of the response required from the hospital.	No change has been made in response to this comment. The Department revised section 96051.6 (d)(1) to allow hospitals 30 calendar days to respond to Department correspondence regarding policy submission and revisions.	3-2
§ 96051.7. Discount Payment Program			
- **§ 96051.7 generally**			
24.	Requests addition of new language that states the discount payment policy shall provide financially qualified patients with an extended payment plan that does not exceed the payment amount that the hospital would expect to receive from Medicare or Medi-Cal, whichever is greater. If there is no established rate, the hospital shall establish an appropriate discounted payment.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. See HSC sections 127405(d) and 127410.	2-34
25.	Requests the hospital publish its Medicare, Medi-Cal, and discounted payment rates, as applicable, in a list of shoppable services on the hospital's website.	No change has been made in response to this comment. The Department cannot implement regulations that alter or amend a statute or enlarge or impair its scope.	2-34
26.	States the Act applies to underinsured patients with high medical costs in excess of 10% of income and requests that the regulations provide clarity on this.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. See HSC sections 127400 (c)(1), which defines a "financially qualified patient" as a patient with high medical costs, and	2-9

		127400 (g), which defines “high medical costs” as annual out-of-pocket costs exceeding 10% of a patient’s family income, annual out-of-pocket expenses exceeding 10% of a patient’s family income, or a lower level determined by the hospital in accordance with the hospital’s charity care policy.	
- **§ 96051.7 (a)**			
27.	Requests using “admitting provider” instead of the terms “treating provider” or “referring provider” to determine whether a service is medically necessary because “treating provider” and “referring provider” could refer to many different health care professionals.	Accept in part. The regulation has been modified to change “treating provider” to “supervising health care provider” for the hospital services at issue in the complaint. See section 96051.7(a). No change has been made to “referring provider” as this includes the provider who directed the patient for care at the hospital.	3-8
28.	Requests addition of language to provide the definitions for the types of providers used in this section.	Accept in part. A definition for “supervising health care provider” has been added. No definition has been added for “provider who referred the patient for the hospital services at issue in the complaint” as this term is self-explanatory. See section 96051.7(a)(1).	3-8
29.	Requests hospital be able to consult an independent clinician to opine on whether a service is medically necessary in accordance with standards accepted by Medicare, Medi-Cal, and/or other major insurance companies.	No change has been made in response to this comment. The provider who referred the patient to the hospital and the supervising health care provider are the most	3-9

		qualified to determine whether a service is medically necessary. As an Independent Medical Review process is not available through the Department, in the interest of equity, an independent provider chosen by the hospital should not be permitted to override a medical necessity determination by a patient's providers.	
30.	States the regulation is not clear on when a hospital must obtain an attestation. Asks whether an attestation must be obtained every time an application for charity care and/or discount payment is denied on the sole basis that the services are not medically necessary? Or only when the patient files an appeal?	Accept. This comment raises questions about when an attestation must be obtained. The regulation has been modified to specify that hospitals must provide an attestation when rejecting a discount payment application and/or excluding specific services from the discount payment program on the basis that the service(s) was/were not medically necessary. See section 96051.7(a).	3-10
31.	States the regulation clarifies all medically necessary services are eligible for discount payment but is silent regarding charity care. Requests the Department clarify whether all medically necessary care is also eligible for charity care.	No change has been made in response to this comment. This requirement specifically applies to discount payment because the Act allows hospitals greater discretion to determine charity care eligibility. The Department cannot implement regulations that alter or amend a statute or enlarge or impair its scope.	3-11

32.	Requests that reference to “elective” care be removed from ISOR in relation to 96051.7 (a) as elective care is care that can be scheduled but may still be medically necessary. Does not request any changes to the proposed text of 96051.7 (a) itself.	No change has been made in response to this comment. The ISOR will not be amended at this time, but the FSOR will make it clear that all services are considered medically necessary unless a valid attestation is provided by the hospital before a patient is denied eligibility for the discount payment program.	2-6
- **§ 96051.7 (b)**			
33.	Requests the six-month paystub requirement be reduced to a two-month paystub requirement because the six-month requirement may deter individuals who cannot provide six months of paystubs from applying for financial assistance.	Accept in part. The comment requests the six-month paystub requirement be reduced to a two-month paystub requirement, however HSC section 127425(e)(1) requires patients make every reasonable effort to provide the hospital with income documentation. The regulation has been modified to simplify the financial income documentation requirement, provide greater flexibility to patients and hospitals, and to not deter patient applicants, by removing the six-month paystub requirement. See section 96051.7(b).	1-6
34.	Requests addition of the limited circumstances in which a hospital may request tax returns.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is	2-14

		unnecessary. See HSC section 127405 (e)(1).	
§ 96051.8. Applications			
- **§ 96051.8 generally**			
35.	Requests requirement that hospitals provide a way for patients to electronically submit their application form and fill out the application online.	No change has been made in response to this comment. The comment references section 96051.11, however the Department interprets this comment to be in reference to section 96051.8. In drafting the regulation, the Department considered and balanced the burden to hospitals with the implementation of the Act's purpose. The proposed comment does not consider the balance between providing patients with the option to submit electronically and the potential burden this may impose on small hospitals.	1-7
36.	States the Department fails to consider circumstances in which a hospital has a discount payment policy but does not provide free care to self-pay patients.	No change has been made in response to this comment. The comment does not provide sufficient specificity for the Department to make any modifications to the text.	2-35
37.	Requests clarification that when a hospital uses a single application, the hospital shall make clear what information is required for charity care and what information is required for discount payment.	No change has been made in response to this comment. The Department believes the regulation is already sufficiently clear and the suggested language will not add clarity.	2-35

38.	Requests addition of new language that hospitals shall not consider assets when determining a patient’s eligibility for discounted payment, however assets may be considered for determining a patient’s eligibility for charity care.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. See HSC section 127405 (e)(1).	2-35
- **§ 96051.8 (a)(1)**			
39.	States support for the Department's decision to not find patients ineligible for discounted payment when they do not provide financial documentation.	No change has been made in response to this comment. The Department interprets this comment to refer to how the hospital may only request limited financial documentation to determine a patient’s discount payment eligibility. The comment concurred with the proposed regulation, so no further response is required. The Department modified this provision in response to another comment. See response #40.	1-2
40.	Requests addition of new language: “(a) A hospital shall provide an application for eligibility for discount payment that is consistent with the Act. The hospital shall specify in the application which patients are eligible for discount payments. For patients applying only for discount payment, the hospital may only request recent paystubs or income tax returns for documentation of income. The hospital may accept other forms of documentation of income but shall no require such other forms.”	Accept in part. The Department does not believe all of the suggested language is necessary or helpful. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. However, the Department modified this provision to include “the hospital may accept other forms of documentation of income but shall not require such	2-35

		other forms." See section 96051.8(a)(1).	
- **§ 96051.8 (a)(2)**			
41.	Requests deletion of § 96051.8 (a)(2) because after the consideration of a patient's essential expenses, a patient may have zero income available even if the patient if not eligible for free care under the hospital's charity care policy.	No change has been made in response to this comment. The regulation is necessary because it requires hospitals using combined discount payment and charity applications to advise patients that they *may* receive less financial assistance if they opt to only provide the financial documentation necessary to determine discount payment eligibility. This gives the patient more information to better determine if they would like to apply for the discount payment program, charity care program, or both.	2-35
ARTICLE 3. NOTICE AND POSTING REQUIREMENTS			
- **Article 3 generally**			
42.	Suggests the Department provide user-tested standardized notices and postings at "an appropriate level for a low-income population."	No change has been made in response to this comment. The comment does not provide sufficient specificity to the Department to make any modifications to the text. At this time, the Department has not addressed the issue of model notices and postings. To meet the January 1, 2024, deadline set forth by the Act, the Department prioritized the drafting of	2-36

		regulations that operationalize and assist in the immediate implementation of the law. Further analysis on this issue is required to determine whether a regulation regarding model notices is necessary.	
43.	Requests clarification regarding whether a patient's documents must be sent on paper (hard copy) or may be sent to the patient's email address.	No change has been made in response to this comment. The only document required to be provided in hardcopy format is the written discharge notice, as specified in the regulation. Electronic delivery of other notices and communications is compliant with the requirements of the regulation.	3-3
44.	Requests the Department provide guidance to hospitals regarding their compliance obligations when a patient has provided neither a street nor email address.	No change has been made in response to this comment. This comment requests guidance on a hospital's obligation when a patient has not provided an address. Providing contact information is a patient's responsibility. If a hospital can demonstrate the patient did not provide address information, the hospital will have met its responsibility.	3-4
45.	Concurs with other legal services organizations that user testing of both notices and postings would improve the documents for consumers.	No change has been made in response to this comment. The comment does not provide sufficient specificity for the	2-4

		Department to make any modifications to the text.	
§ 96051.9. Discharge Notice			
- **§ 96051.9 (a)(3)(B)**			
46.	Supports the Department's decision to require hospitals provide patients with a discharge notice that includes information on where and how to access discount payment and charity care policies.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	1-3
- **§ 96051.9 (b)**			
47.	Requests clarity regarding the "proof" a hospital must maintain to demonstrate a written discharge notice was provided to a patient. Asks whether a hospital must capture a patient's signature or whether a hospital employee's documentation that a notice was given is sufficient.	Accept. The regulation has been modified to clarify a contemporaneous record will suffice as sufficient proof. See section 96051.9(b).	3-5
48.	Requests a reasonable record retention period be included in the regulations.	No change has been made in response to this comment. As the comment states, hospitals are already required to follow numerous state and federal laws regarding record retention. Notable examples include 22 CCR § 70751 (requiring retention of patient medical records for 7 years following discharge of patient, or, for minor patients, at least 1 year after the minor has reached 18 years of age, but not less than 7 years following discharge of patient); WIC § 14124.1 (requiring retention of Medi-Cal records for 10	3-6

		years from the date the service was rendered); and 42 CFR § 422.504(d) (requiring retention of Medicare and Medicaid records for 10 years). So long as hospitals are in compliance with record retention laws such that they are able to provide the Department with records when those records are requested during existing legal retention periods, additional record retention regulations related only to the Act are unnecessary.	
§ 96051.10. Hospital Postings			
- **§ 96051.10 generally**			
49.	Supports the provisions regarding public notice of the availability of the State complaint unit in the proposed regulation.	The Department appreciates this comment of support. No change has been made in response to this comment.	2-3
50.	Raises concerns about signage requirements given the required font sizes, required content, and limited wall space. Requests the Department adopt a font size that would fit on one 11x17 size.	Accept. Removed minimum font size requirements. See section 96051.10(a)(1).	3-12
51.	Recommends the Department consider adopting specifications for electronic signage.	No change has been made in response to this comment. The Department is unable to address the issue of electronic signage at this time. To meet the January 1, 2024, deadline set forth by the Act, the Department prioritized the drafting of regulations that operationalize and assist in the immediate implementation of the	3-13

		law. Further analysis on this issue is required to determine whether a regulation regarding electronic signage is necessary.	
- **§ 96051.10 (c)**			
52.	Requests the Department staff have authority to inspect hospital postings at any time because the visibility may be different on a crowded Saturday night versus a quiet Wednesday morning (e.g., a notice could be blocked if someone stood in front of it). Additionally, a billing office may not be open on a weekend.	No change has been made in response to this comment. The Department does not believe it is necessary or helpful for the Department staff to inspect hospital postings outside of business hours. Possible crowds in an emergency department and a billing office being closed on the weekend are outside the scope of the requirements of the Act and its corresponding regulations.	2-36
- **§ 96051.10 (d)**			
53.	Supports the provision that does not require the Department staff to inform the hospital of its findings and states the provision would be strengthened by prohibiting the Department staff from informing the hospital of its findings at the time of inspection as hospital management may attempt to sway the State's findings.	No change has been made in response to this comment. The Department interprets the comment as an observation rather than a specific recommendation to change these regulations.	2-36
54.	Requests revision to require Department staff to notify the hospital of any deficient signage at the time of inspection, unless the Department staff believes doing so would be inadvisable because it benefits everyone for signage to come into compliance as soon as possible.	No change has been made in response to this comment. Nothing prevents Department staff from informing hospital staff of its findings. However, due to time constraints, Department staff should not be required to locate and notify an appropriate hospital	3-14

		staff member in order to complete its inspection.	
§ 96051.11. Website Requirements			
- **§ 96051.11 (a)(1)**			
55.	Supports the Department decision to require hospitals to have a webpage titled “Help Paying Your Bill.”	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	1-4
ARTICLE 4. HOSPITAL BILL COMPLAINT PROGRAM			
§ 96051.12. Hospital Designated Contact and Statement of Certification			
56.	Requests clarity on where a requirement for a contact at the hospital to whom a patient can complain exists.	No change has been made in response to this comment. The comment requests a restatement of the statute that does not provide any additional clarity and is unnecessary. See HSC section 127405 (a)(1)(A), which, in the event of a dispute, allows a patient to seek a review from the hospital’s business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.	2-37
§ 96051.13. Patient Complaint Portal			
57.	States that the ability to complain by telephone is important for many patients. Acknowledges that the Department is not currently staffed to provide this service but states that it should be.	No change has been made in response to this comment. The Department does not currently have resources for a call center but hopes to in the future.	2-38

§ 96051.14. Authorized Representative			
58.	States no additional comment; defers to Western Center on Law and Poverty.	No change has been made in response to this comment. The comment does not provide sufficient specificity for the Department to make any modifications to the text.	2-39
59.	Requests local health departments be exempt from the patient authorization requirement and allowed to submit a complaint on behalf of any patient in their jurisdiction.	No change has been made in response to this comment. To safeguard protected health information, complaints should not be opened without a patient's (or individual designated by law to act on behalf of the patient) express permission. Nothing in this regulation prevents a local health department representative from acting as a patient's authorized representative with the patient's signed consent.	1-5
§ 96051.15. Release of Information			
60.	Comment recommends a form that complies with all types of services and notes that different types of services (i.e., acute psychiatric vs. general acute services) have different release requirements.	No change has been made in response to this comment. The content of the release of information is not set forth in the regulations. As pointed out by the comment, the release of information can be different dependent on a number of different factors, including the hospital type, services received and age of patient. The release of information will incorporate all these factors.	3-17

61.	Comment notes that in some circumstances, the authorized representative may not have authority to release information (i.e., sexual and reproductive services for a minor child).	Accept in part. The Department has deleted the term "authorized representative." The regulation as revised will require the patient (or someone with legal authority to act on behalf of the patient) to sign for the release of information.	3-18
62.	Comment reminds the Department that AB 1697, a proposed amendment to Civil Code section 56.05, may limit a release of information to one year.	No change has been made in response to this comment. Proposed regulation states that a signed release of information is required for each complaint and will be valid until the investigation is closed or the release is revoked by the patient. The medical release will be subject to the regulations currently set forth in Civil Code section 56.05.	3-19
63.	Requests clarity on how a patient will know they need to sign a release of information when filing a complaint.	No change has been made in response to this comment. Patients will be advised by the Department during the complaint process when a release of information is required.	2-40
§ 96051.16. Filing a Patient Complaint			
- **§ 96051.16 generally**			
64.	Recommends that the Department require hospitals to provide a way for patients to electronically submit their discount payment/charity care program applications and fill out the application form online.	No change has been made in response to this comment. The Department interprets this comment in response to section 96051.16 generally (filing a patient complaint). In drafting the regulation, the Department made	1-7

		an effort to balance the burden to hospitals with the implementation of the Act's purpose. The proposed comment does not provide a discussion of the balance between providing patients with meaningful access to financial assistance and the potential burden this may impose on hospitals.	
65.	Requests the Department make complaints consumer-friendly and accept verbal complaints as many consumers lack the capacity to file written or electronic complaints.	No change has been made in response to this comment. At this time, the Department does not have the resources to accept verbal complaints. Regarding making complaints more consumer-friendly, the Department made additional data elements on the patient complaint optional in response to another comment. See response #67.	2-15 2-41
66.	Recommends that patients be required to provide the following with all complaints: name used at the hospital, their hospital medical record number, a statement verifying they submitted a complete financial assistance application with all required information and timely responded to all requests for information from the hospital, and a copy of the patient's completed financial assistance application, if available.	No change has been made in response to this comment. Patient complaints will already include numerous patient identifiers and other information necessary to evaluate patient complaints. Hospitals will be able to provide this information more easily than patients under significant stress and often with limited means.	3-29 3-30
- **§ 96051.16 (b) generally**			
67.	Requests the Department reduce the burden on patients filing complaints by limiting the information	Accept in part. The Department modified the regulation such that all	2-41 2-16

	required to process a complaint, especially § 96051.16(b)(21)-(29). Notes other requested information such as in § 96051.16(b)(1)-(10) and some in § 96051.16(b)(11)-(20) may be able to be provided more readily by the patient. Stated the hospital already has much of the required information and the requirements to file are unrealistic from a consumer perspective. For example, how can a consumer know the date when a hospital sold their debt to collections? How can a consumer be certain of the date their health plan denied coverage?	data elements that are not necessary for the Department to complete its investigation are now listed as “required only if available” or “optional.” If an optional data element is not provided, the complaint will still be processed. See section 96051.16(b).	
68.	Requests the Department reduce the data element requirements for complaints, including address information that would be difficult for unhoused individuals to provide. Additionally, asks the Department to ensure partial applications get reviewed if submitted by mail.	Accept in part. The regulation has been modified so patients are only required to provide a mailing address if one is available. Complaints will still be processed when address information is not provided. See section 96051.16(b)(6). The commenter also requests the Department ensure partial applications get reviewed if submitted by mail. No change has been made in response to this comment, however the Department made additional data elements on the patient complaint optional in response to another comment. See response #67.	1-8

69.	Asks: What happens if a consumer does their best but cannot provide all of these items? Is the complaint invalidated? Can the hospital use the failure of a consumer to provide information that is only in the hospital's possession or most readily available to the hospital as a means to evade enforcement?	No change has been made in response to this comment. The comment does not provide sufficient specificity to the Department to make any modifications to the text. However, the Department modified this provision in response to another comment and reduced the required information on patient complaints. See response #67.	2-41
70.	Asks: How will the Department handle a situation in which a consumer omits an item such as a signed authorization of release? The list of 29 data elements is unrealistic for consumers who have a lot of paperwork to sift through and may be burdened with serious illness.	No change has been made in response to this comment. The Department modified the regulation such that all data elements that are not necessary for the Department to complete its investigation are now listed as optional or required only if available. See response #67. However, if the patient/authorized representative with legal authority to act on behalf of the patient does not provide a signed release of information, the Department would be unable to investigate the complaint.	2-16
- **§ 96051.16 (b)(4)**			
71.	Asks: What is the relevance of the data element "sex"?	No change has been made in response to this comment. The Department requests the patient's sex in order to match the patient to the correct hospital record. Although an entry is required, the	2-41

		patient has the ability to select “female,” “male,” “unknown,” or “prefer not to say.” If the patient prefers to not provide their sex on their complaint, they may select “prefer not to say” and their complaint will still be investigated.	
- **§ 96051.16 (b)(20)**			
72.	Asks: What if a consumer’s complaint is that the hospital prevented them from filing a discount payment application? How would 96051.16(b)(20) apply?	No change has been made in response to this comment. If the patient did not submit an application to the hospital prior to filing a complaint, the Department will still investigate the hospital’s compliance with notice requirements and all other requirements that are not related to an eligibility determination.	2-41
- **§ 96051.16 (b)(22)**			
73.	Asks: What if a consumer was not provided notice? How would they comply with 96051.16(b)(22)?	Accept. The Department modified to regulation to reflect this data element as optional. See section 96051.16(b)(22).	2-41
§ 96051.17. Complaint Review			
- **§ 96051.17 (a)**			
74.	States that patient complaints should not be limited to patients who have already submitted an application for discount payment and/or charity care, and that patients should be able to make complaints unrelated to financial assistance eligibility determinations.	Accept. Department has modified the text of section 96051.17 (a) to read as follows: For the Department to investigate an eligibility determination by a hospital for its discount payment and/or charity care programs, the patient or their authorized	1-9 2-17 2-42

		representative must have already submitted an application for discount payment and/or charity care to the hospital for the services at issue in the complaint.	
75.	Comment requests regulations require Local Health Departments (LHD) be notified of any patient who files a complaint in their jurisdiction. This would allow LHDs to conduct outreach to patients to ensure they have access to necessary information and connect them to the appropriate resources and services and to monitor the volume of complaints by the facility and work with facilities to improve their practices.	No change has been made in response to this comment. To safeguard protected health information, the Department cannot share complaint information with the LHD without the patient's signed consent.	1-10
- **§ 96051.17 (b)(1)**			
76.	States that 10-day time frame to respond to the Department regarding patient complaints with a detailed explanation and copies of all relevant documents is too short and requests this be revised to 30 calendar days.	Accept. Section 96051.17 (b)(1) has been revised to allow hospitals 30 calendar days to respond to the Department regarding patient complaints.	3-1
- **§ 96051.17 (d)(1)**			
77.	States that 10-day time frame to respond to Department requests for additional information or records from the patient or hospital is too short and requests this be revised to 30 calendar days.	Accept. Section 96051.17 (d)(1) has been revised to allow patients and hospitals 30 calendar days to respond to Department requests for additional information or records.	3-1
§ 96051.18. Request for Extension			
78.	States that, if the Department does not adopt the 30-calendar day timeframe proposed in comment 3-1, alternatively the Department could create a process for hospitals to request and receive an automatic extension based on the complexity of the response required from the hospital.	No change has been made in response to this comment. The Department revised sections 96051.17 (b)(1) and (d)(1) to allow hospitals 30 calendar days to respond to Department	3-2

		correspondence regarding patient complaints or requests for additional information or records.	
§ 96051.19. Debt Collection Ceased While Complaint Pending			
79.	States that the Department lacks statutory authority to promulgate regulation requiring all collections activity to cease while a patient's complaint is pending with the Department. States that HSC section 127425 (g) does not require hospitals to cease all collection efforts. Asserts that ceasing all collection activities may prevent a hospital from sending information about a bill to a patient even at the patient's request.	Accept in part. The proposed language has been narrowed in scope to more closely align with the language of HSC section 127425 (g). The Department has revised section 96051.19 as follows: "The hospital shall not send the unpaid bill to any collection agency, debt buyer, or other assignee, unless that entity has agreed to comply with the Act, after the hospital has been notified that the patient has filed a complaint with the Department. This shall apply only to the bill(s) for which the patient has filed a complaint with the Department. Failure to comply with this section is grounds for a penalty under this chapter."	3-20

80.	Requests that any restriction on collection activities which may result in penalties should only apply once a hospital is notified of the complaint by HCAI, and a hospital should not be fined for pursuing collections when it was not aware of a complaint.	Accept. Section 96051.19 has been revised as follows: “The hospital shall not send the unpaid bill to any collection agency, debt buyer, or other assignee, unless that entity has agreed to comply with the Act, after the hospital has been notified that the patient has filed a complaint with the Department. This shall apply only to the bill(s) for which the patient has filed a complaint with the Department. Failure to comply with this section is grounds for a penalty under this chapter.”	3-21
ARTICLE 5. PENALTIES			
§ 96051.20. Applicability			
81.	Comment requests 180 days from day regulations go into effect before the Department enforces violations, to give Hospitals time to complete work necessary to comply.	No change has been made in response to this comment. The Department notes that hospitals will have had two years to comply with the requirements set forth in the Act prior to commencement of the Department’s enforcement authority.	3-28
§ 96051.21. Penalties for Late Filing of Documents and Responses			

82.	Comment asserts penalties for late filing are excessive, and disproportionate to other violations, noting that an actual violation of the Act is limited to $40,000 when a patient files a complaint. The comment also notes that a hospital could unknowingly accrue a penalty of $730,000 for a failure to submit a biennial report because the regulations indicate the Department would not send the notice of accrued penalty for two years. Comment also notes that the Legislature instructed the Department to take into account the actual harm to the patient and the willfulness of the violation when setting the final amount of the penalty in cases involving a patient complaint. The comment acknowledges the language technically applies only when a patient has filed a complaint, but indicates it is the legislative intent that penalties be proportionate to the patient's harm and willfulness of the misconduct involved.	Accept in part. The penalty for submitting documents late will be reduced to $500 per day. This reduction balances the concerns of the commentor regarding disproportionate outcomes while still maintaining fines that are sufficiently weighted to incentivize compliance. The comment that the Department would wait two years to notify the hospital of a failure to submit a document would not happen. Under the previous statute, the Department was tasked with collecting policies and procedures for discount payment programs and charity programs and posting the documents to its website without review. The Act added a requirement that the Department review the policies and procedures for compliance with the Act. When the Department reviews a hospital's submission (or lack thereof) it will note that the hospital failed to submit the document and notify the hospital. Additionally, the new Department policy submission portal (HDC) will show the status of any submitted document. Hospitals will be able to view the documents that were submitted. Given the	3-32

		Department's role in reviewing policies and procedures for compliance and the Department's new system, a failure to submit a policy or procedure would not go undetected for two years. Additionally, if a hospital has concerns that the document it submitted was not received by the Department, the hospital can contact the Department for confirmation of receipt. Further, given the intent of this section is to encourage compliance with Department deadlines, standardized fine of $500 per day is appropriate.	
83.	Comment requests that penalties for late filings do not accrue until hospital is notified by the Department that policy submission is late. Recommends that the Department adopt a provision stating that late penalties for failure to submit biennial reports pursuant to section 96051.6 (b)(1), or failure to timely respond pursuant to sections 96051.6(d)(1), 96051.17(b)(1), or 96051.17(d)(1) *begin upon the HCAI notification to the hospital that it did not receive a certain submission."*	No change has been made in response to this comment. Hospitals are aware of biennial reporting periods (every other year on even years). Additionally, it is the hospital's responsibility to regularly check the policy submission portal during the reporting period to respond to the Department requests for information and to ensure all submitted policies have been approved. Likewise, it is the hospital's responsibility to regularly check the patient complaint portal for incoming patient complaints and	3-33

		the Department requests for information related to the patient complaint process. It should be noted that, as a courtesy, the new policy submission portal will auto notify if a document has not been timely submitted.	
84.	Comment requests that penalties for late filing and responses be reduced to $100 per day.	Accept in part. The penalty for submitting documents late will be reduced to $500 per day. This balances the concerns of the commentor regarding disproportionate outcomes while still maintaining fines that are sufficiently weighted to incentivize compliance.	3-34
85.	Comment recommends a system that notifies the hospital automatically when it has received a document, and how many pages were received. Otherwise, a hospital will have no way of knowing (or proving) that the Department received what the hospital transmitted.	The Department interprets the comment as an observation rather than a specific recommendation to change these regulations. The new Department policy submission portal (HDC) will show the status of any submitted document. Additionally, Hospitals will be able to view the documents that were submitted, as well as different drafts that were submitted prior to a policy being approved by the Department.	3-35
86.	Comment recommends a system that notifies a hospital electronically if the Department sends, by U.S. mail, any information requiring a response.	The Department interprets the comment as an observation rather than a specific recommendation to	3-36

	This will allow the hospital to notify its mail room to be on the lookout for the time-sensitive mailing.	change these regulations. The new Department policy submission portal (HDC) and patient complaint CRM will generate all correspondence electronically, even if it is also sent via U.S. Mail. The hospital will receive an electronic version of all correspondence and will be advised that the correspondence is also being mailed via U.S. Mail.	
§ 96051.23. Penalty Assessment for Violations of Notice and Hospital Policy Requirements			
- **§ 96051.23 (a)**			
87.	Comment requests that the section be redrafted to include billing practices and collection practices in violation of the Act.	No change has been made in response to this comment. This section was specifically drafted to only address hospital policy submissions, notices and website violations. Violations of hospital billing practices or collection practices will be enforced under sections 96051.24 through 96051.27.	2-8 2-43
- **§ 96051.23 (b)**			
88.	Comment expresses confusion regarding the process of assessing of fines. Comment presents questions regarding how a penalty would be assessed under various circumstances.	No significant change has been made in response to this comment. The comment misinterprets the regulation, presenting examples that would not be processed under this subsection. The examples provided would be specific	2-44

		violations regarding specific patients. Violations related to specific patients arising out of the complaint process will be assessed under sections 96051.24 through 96051.27. This section is intended to enforce violations of the Act and the regulations that are systemic in nature, not related to individual patients.	
89.	Comment notes that section 96051.23 states that multiple violations of a poster or policy requirement will result in multiple penalties. Comment asserts this contradicts the plain language of the authorizing statute. Therefore, section 96051.23 (b) must be revised to read similarly to section 96051.24 (a), namely that all violations arising out of a single investigation are subject to one penalty assessment.	No change has been made in response to this comment. The Department determined that the requirement that multiple violations identified during an investigation as set forth in HSC section 127436 applies to patient complaints only and that the authority to draft regulations regarding penalties for violations of policies, notice, posters, and websites requirements falls under HSC sections 127410, 127435, and 127436. HSC section 127436 provides that the Department "shall impose an administrative penalty for each violation against a hospital that fails to comply with this **article**" and that "for the purpose of this **section** [referring to 127436 which speaks to patient complaint process], multiple violations identified during the same **investigation** shall	3-22 3-27

		constitute a single violation for purposes of assessing an administrative penalty." The drafters did not apply the 40K cap to violations of the article, but rather specifically to violations of the section.	
90.	Comment recommends clarifying the definitions of major, moderate, and minor and adding a de minimis category.	Accepted in part. A change has been made to the section to clarify the term "Moderate." Commentor believes the terms are unclear, but the Department does not. This section refers to review of policies, postings, and website requirements. These violations do not relate to a specific patient complaint but rather, to systemic violations. An impact to patient eligibility refers to conditions that determine patient eligibility such as an incorrect representation of the FPL, or the definition of family size in the policy. Violations that do not directly impact eligibility but have the potential to impact a patient's ability to receive discount payment or charity care would apply to violations of requirements regarding notices, posting and other issues that could affect the ability to apply.	3-23 3-25
91.	Comment requests the Department add a category of de minimis violation to the penalty structure.	Accepted in part. The Department determined it is appropriate to	3-24 3-26

	Such violations should automatically receive no penalty if the hospital takes corrective action as directed by the Department. This should not be subject to the discretion of a department employee.	modify subsection (b)(4), which addresses violations that did not affect patient access to, or eligibility for, the discount payment program or the charity care program, to remove the Department discretion. There will be no penalty in circumstances where the violation does not affect patient access to or eligibility for the hospital's discount payment or charity care programs, provided the hospital takes appropriate corrective action as directed by the Department.	
- **§ 96051.23 (c)**			
92.	Comment expresses confusion regarding (c), which states that "penalties for violations of Health and Safety Code section 127436 shall be excluded from this section."	Accepted. This section has been revised to clarify and correct an error. Section 96051.23 is intended to deal with violations of the Act that do not arise out of the patient complaint process. This section deals with systemic violations resulting from policies and applications, postings, and websites that are out of compliance. The subsection has been revised to indicate that violations of the Act that arise out of the patient complaint process will be enforced under sections 96051.24 through 96051.27.	2-45
§ 96051.28. Failure to Reimburse Patient and Pay Assessed Penalty			

93.	Comment notes a hospital's repayment obligation is not limited to when the Department intervenes and asks that the regulation text be revised to be consistent with the statute requiring hospitals repay consumer within 30 days, beginning when hospital is made aware of the error.	Accepted in part. The comment provided specific language that was not adopted. However, the recommended change was made to include language affirming the hospital's obligation to repay the patient pursuant to HSC section 127440 when the hospital discovers a patient overpayment.	2-7 2-46
ARTICLE 6. APPEALS			
§ 96051.35. Conduct of Hearing			
94.	Comment requests that all appeals go before an administrative law judge employed by the California Office of Administrative Hearings (OAH), raising concerns that the Department hearing officer will be unable to set aside any potential bias and provide a fair hearing.	No change has been made in response to this comment. The Department has a dedicated hearing officer for other programs and is able to set aside any potential bias and provide a fair hearing.	3-37
§ 96051.37. Decision			
95.	Comment asks that section 95051.37 be amended to state that the Director's decision is subject to review under the Code of Civil Procedure Section 1094.5.	No change has been made in response to this comment. The comment requests a restatement of law that does not provide any additional clarity and is unnecessary.	3-38

Other			
96.	Comment notes, HSC 127435 (c) states, "A patient shall not be denied financial assistance that would	No change has been made in response to this comment. The	3-39

	be available pursuant to the policy published on the department's internet website at the time of service." Comment note this makes it incumbent upon the Department to post the hospital's policy on the Department's website by the date the policy takes effect. Comment states that a hospital should never be penalized because of a department delay in posting the policy.	Department interprets the comment as an observation rather than a specific recommendation to change these regulations. Under the new policy submission process via the new policy submission portal, the hospital is required to upload a clean version for posting on the Department's website and a marked-up version which reflects any changes since the policy was last submitted to the Department, using underline to identify new content and strikethrough to identify removed content. The pdf version will be posted to the Department's website on the effective date noted by hospital, with a status "pending review."	
97.	Comment requests clarification that limits on residency by specified geographic area are not allowed in hospital policies.	No change has been made in response to this comment. Nothing in the Act provides hospital the ability to limit geographic area.	2-10
98.	Comment requests clarification that time limits during the life of the debt are not allowed – so long as a patient owes the hospital for care, they should be eligible for discount payment.	No change has been made in response to this comment. The comment requests a restatement of law that does not provide any additional clarity and is unnecessary. HSC section 127405 (e)(4) states that eligibility for discounted payments or charity	2-11

		care may be determined at any time the hospital is in receipt of information necessary to determine eligibility.	
99.	Requests a time limit for patients to file complaints under the Act.	No change has been made in response to this comment. This request is contrary to the Act, specifically HSC section 127405 (e)(4).	3-7 3-31
100.	Requests the Department add clarification that consumers may apply for financial assistance at any time, even during debt collection process or litigation on debts.	No change has been made in response to this comment. The comment requests a restatement of law that does not provide any additional clarity and is unnecessary. HSC section 127405 (e)(4) states that eligibility for discounted payments or charity care may be determined at any time the hospital is in receipt of information necessary to determine eligibility.	2-19
101.	Comment asks that clarification be added to the regulations, confirming that undocumented immigrants are eligible if they are otherwise financially qualified.	No change has been made in response to this comment. Nothing in the Act provides hospitals the ability to limit a patient's eligibility based on their immigration status.	2-12
102.	Comment notes that the written policies of hospitals consistently fail to comply with the requirements of state law and that omission of substantive requirements from the proposed regulations risks continuing this failure.	No change has been made in response to this comment. The Department interprets the comment as an observation and summary of previous comments	2-20

		rather than a specific recommendation to change these regulations.	

FSOR APPENDIX B: SUMMARY AND RESPONSE TO COMMENTS SUBMITTED DURING 15-DAY COMMENT PERIOD

Response #	Summary of Comment	Response	Comment #s
CHAPTER 9.2: HOSPITAL FAIR BILLING PROGRAM			
ARTICLE 1. DEFINITIONS; DOCUMENT ACCESSIBILITY; ELIGIBILITY DETERMINATION LETTERS; HOSPITAL BILL COMPLAINT PROGRAM NOTICE; AND HOSPITAL DELEGATION			
§ 96051. Definitions			
1.	Appreciates addition of “discount payment” definition which differentiates discount payment and charity care.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	4-3
2.	Appreciates revision of “charity care” definition to include both free care provided without expectation of payment and reduced cost services provided to patients who qualify under a hospital’s charity care policy.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	4-3
ARTICLE 2. DISCOUNT PAYMENT, CHARITY CARE, AND DEBT COLLECTION POLICIES AND PROCEDURES			
§ 96051.7. Discount Payment Program			
- **§ 96051.7 generally**			
3.	Appreciates requirement that discount payment policies be in accordance with the	No change has been made in response to this comment. The	4-4

	Act but would prefer that the regulations incorporate the requirements of the Act.	comment does not provide sufficient specificity for HCAI to make any modifications to the text.	
- **§ 96051.7(a)**			
4.	Appreciates correction with respect to medically necessary services and the revised standard for determining whether such services were not medically necessary.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	4-5
5.	Appreciates correction of “elective” care.	No change has been made in response to this comment. The proposed regulations have never referenced “elective” care, and the only reference to “elective” care appears in the ISOR. The proposed regulations state that all services are considered medically necessary unless a valid attestation is provided by the hospital before a patient is denied eligibility for the discount payment program.	4-6
- **§ 96051.7(b)**			
6.	Appreciates deletion of the requirement that patients submit six months of consecutive paystubs as the requirement was overly burdensome.	No change has been made in response to this comment. It appears to misunderstand the regulation. The regulation did not require six months of	4-7

		consecutive paystubs, but rather set a maximum limit on the number of paystubs that may be requested. The Department, however, was concerned six months would become a default requirement and thus removed the referenced duration.	
ARTICLE 3. NOTICE AND POSTING REQUIREMENTS			
- **Article 3 generally**			
7.	Requests creation of standardized notices, postings, and website information, as well as a "notice review" committee to develop standardized materials that includes all relevant stakeholders.	No change has been made to the regulations as the comment is not related to the 15-day changes in the modified text.	4-9
ARTICLE 4. HOSPITAL BILL COMPLAINT PROGRAM			
§ 96051.16 Filing a Patient Complaint			
- **§ 96051.16(b)**			
8.	Appreciates revision to information required in a patient complaint and addition of the term "if applicable and available."	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	4-8
§ 96051.19 Debt Collection While Complaint Pending			
9.	States that the title of this section no longer reflects the language of the section. Supports prior version of proposed regulation text for this section which	No change has been made in response to this comment. The Department cannot implement regulations that are overly broad	4-10

	required debt collection to cease while patient complaint was pending.	and exceed its statutory authority. However, the title of this section has been modified for consistency with the language of the proposed regulation.	
10.	Appreciates change requiring hospitals to impose conditions on contracts with debt collectors and debt buyers.	The Department appreciates this comment of support. No change has been made in response to this comment. The comment concurred with the proposed regulations, so no further response is required.	4-10
ARTICLE 5. PENALTIES			
§ 96051.21 Penalties for Late Filing of Documents and Responses			
11.	The commentor regrets the lowering of the penalty for failing to file timely, from $1,000 to $500.	No change has been made in response to this comment. The Department interprets the comment as an observation rather than a specific recommendation to change these regulations. The Department determined that a reduction of the fines from $1,000 per day to $500 per day is appropriate to best balance the need to encourage the hospitals' timely compliance while also taking into consideration the hospitals' financial stability.	4-11

12.	The comment indicates the fine for late filing of documents and responses is disproportionately high and, in some cases, may not align with the severity of the violation. The comment notes that a hospital could unknowingly accrue a penalty of $365,000 for a failure to submit a biennial report because the regulations indicate the Department would not send the notice of accrued penalty for two years.	No change has been made in response to this comment. Similar concerns regarding excessive fines and disproportionality were raised after the original proposed text were published. The penalty for submitting documents late has been reduced from $1,000 per day to $500 per day. The comment that the Department would wait two years to notify the hospital of a failure to submit a document would not happen. Under the previous statute, the Department was tasked with collecting policies and procedures for discount payment programs and charity programs and posting the documents to the Department website without review. The Act added a requirement that the Department review the policies and procedures for compliance with the Act. When the Department reviews a hospital's submission (or lack thereof) it will note that the hospital failed to submit the document and notify the hospital. Additionally,	5-3

		the new Department policy submission portal (HDC) will show the status of any submitted document. Hospitals will be able to view the documents that were submitted. Given the Department's role in reviewing policies and procedures for compliance and the Department's new system, a failure to submit a policy or procedure would not go undetected for two years. Additionally, if a hospital has concerns that the document it submitted was not received by the Department, the hospital can contact the Department for confirmation of receipt. The previously made reduction in the fine from $1,000 per day to $500 per day balances the concerns of the commentor regarding disproportionate outcomes while still maintaining fines that are sufficiently weighted to incentivize compliance.	
13.	The commentor suggests an addition to the regulation that late penalties for a failure to submit biennial reports or for failure to timely respond to the Department, should	No change has been made in response to this comment. Hospitals are aware of biennial reporting periods (every other	5-4

	not accrue until after the Department notifies the hospital that the Department did not receive the required submission.	year on even years). Additionally, it is the hospital's responsibility to regularly check the policy submission portal during the reporting period to respond to the Department requests for information and to ensure all submitted policies have been approved. Likewise, it is the hospital's responsibility to regularly check the patient complaint portal for incoming patient complaints and the Department requests for information related to the patient complaint process. It should be noted that, as a courtesy, the new policy submission portal will auto notify if a document has not been timely submitted.	
14.	The penalty should be reduced from $1,000 per day to $100 per day and should take into account any patient harm, willfulness of misconduct, and any other factors listed in Health and Safety Code (HSC) section 127436. Commentor also notes the Department should be able to use its discretion to close an investigation without a penalty, as stated in section 96051.23 (b)(4).	No change has been made in response to this comment. The penalty was previously reduced from $1,000 per day to $500 per day. The Department will not be weighing an individual patient's harm or the willfulness of the misconduct because a violation in these circumstances will be systemic in nature, and thus has	5-5

		the potential of harming the entire patient population. As the intent of this section is to encourage compliance with Department deadlines, a standardized fine of $500 per day is appropriate.	
§ 96051.23 Penalty Assessment for Violations of Hospital Policy, Posting, and Website Requirements			
15.	The commentor indicates the concern that there is no process to address a hospital's failure to comply with the hospital's policies and suggested language be added to section 96051.23 to correct the perceived omission.	No change has been made in response to this comment. Violations related to specific conduct that violates the Act or the corresponding regulations will be assessed under sections 96051.24 through 96051.27. This section is intended to enforce violations of the Act and the regulations that are systemic in nature, not related to individual patients.	4-12 4-18
§ 96051.23 (a)(3)			
16.	The commentor expresses regret in the removal of the Department's discretion in determining whether to assess no fine in cases where the violation did not affect patient access to or eligibility for the discount payment or charity care programs.	No change has been made in response to this comment. The Department determined it is appropriate to modify the original proposed text of subsection (b)(4), which addresses violations that did not affect patient access to, or eligibility for, the discount payment program or the charity care	4-13

		program, to remove the Department discretion. This change is necessary to provide the clearest possible penalty structure and to balance the intent of the Act to provide patients with meaningful access to financial assistance with the potential financial burden the penalty may impose on hospitals.	
§ 96051.23 (b)			
17.	The comment believes the penalties assessed under section 96051.23 are not in compliance with HSC section 127436 (a) and that multiple violations identified during the same investigation should constitute a single violation for purposes of assessing an administrative penalty.	No change has been made in response to this comment. The Department determined that the requirement that multiple violations identified during an investigation as set forth in section 127436 applies to patient complaints only and that the authority to draft regulations regarding penalties for violations of policies, notice, posters, and websites requirements falls under HSC sections 127410, 127435, and 127436. HSC section 127436 provides that the Department "shall impose an administrative penalty for each violation against a hospital that fails to comply with this **article**"	5-2

		and that "for the purpose of this **<u>section</u>** [referring to HSC section 127436 which speaks to patient complaint process], multiple violations identified during the same **investigation** shall constitute a single violation for purposes of assessing an administrative penalty." The drafters did not apply the $40,000 cap to violations of the article, but rather specifically to violations of the section.	
§ 96051.28 Failure to Reimburse Patient and Pay Assessed Penalty.			
18.	The commentor expresses appreciation that the regulation was revised to clarify that a complaint to the Department by a consumer is not necessary to achieve repayment of overpayments.	The Department appreciates this comment of support. No change has been made in response to this comment.	4-14
19.	The commentor suggests the Department require hospitals to track how frequently, and in what amounts, hospitals reimburse patients for patient overpayments, noting this would assist in enforcement by revealing patterns of lack of compliance.	No change has been made to the regulations as the comment is not related to the 15-day changes in the modified text.	4-15

Other			

Response #	Summary of Comment	Response	Comment #s
20.	Appreciates many of the revisions to the proposed regulations, which more clearly mirror the statutory authority.	The Department appreciates this comment of support. No change has been made in response to this comment.	4-1
21.	Appreciates significant changes to the initial proposed regulations and opportunity to provide input in the second comment period. Believes changes were important and will help hospitals better understand and implement the law.	The Department appreciates this comment of support. No change has been made in response to this comment.	5-1
22.	Seeks further changes including clarity that the penalties will apply if a hospital violates the law in practice, in addition to having a non-compliant policy.	No change has been made in response to this comment. The comment does not provide sufficient specificity for the Department to make any modifications to the text.	4-2
23.	Recognizes and supports efforts from Western Center for Law and Poverty and other legal services organizations to seek other changes and improvements to the regulations.	No change has been made in response to this comment. The Department interprets the comment as an observation rather than a specific recommendation to change these regulations.	4-16
24.	Appreciates that many of the comments made in their 45-day comment letter, dated July 31, 2023, were addressed.	The Department appreciates this comment of support. No change has been made in response to this comment.	4-17