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STATE OF CALIFORNIA

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

TITLE 22, CALIFORNIA CODE OF REGULATIONS

Division 7, Health Planning and Facility Construction

Chapter 9.2, Hospital Fair Billing Program

INITIAL STATEMENT OF REASONS

I. BACKGROUND

The Department of Health Care Access and Information (Department) currently oversees hospital compliance with the Hospital Fair Pricing Act.[1] The Department reviews hospital financial assistance and debt collection policies and financial assistance applications and investigates patient complaints about a hospital's failure to comply with the Hospital Fair Pricing Act.

On January 1, 2024, the Department assumed enforcement of the Hospital Fair Pricing Act from the California Department of Public Health (CDPH) under Assembly Bill 1020 (AB 1020; Chapter 473, Statutes of 2021). AB 1020 expanded eligibility for financial assistance, increased protections for eligible patients, established a patient complaint process, and strengthened state enforcement and oversight of the Hospital Fair Pricing Act.

In 2024, the Legislature passed Assembly Bill 2297 (AB 2297; Chapter 511, Statutes of 2024) and Senate Bill 1061 (SB 1061; Chapter 520, Statutes of 2024), which went into effect on January 1, 2025. The new laws further clarified existing Hospital Fair Pricing Act requirements and added even more patient protections.

II. PROBLEM TO BE ADDRESSED

AB 1020 required the Department to promulgate regulations and commence enforcement by January 1, 2024. The regulations were written based on anticipated processes and procedures that had not yet been put into practice. After over a year of

[1] Health and Safety Code sections 127400 through 127446, inclusive.

performing hospital policy compliance reviews and investigating patient complaints, a cleanup package is necessary to further strengthen and streamline existing language, improve readability, fill in any unintentional gaps, remove repetitive or duplicative language, fix inconsistent wording and syntax, and clarify standards based on feedback received from hospitals.

AB 2297 eliminated many of the distinctions between the eligibility requirements for discount payment and charity care. As a result, some of the existing regulatory text needs amendment or removal to align with the new laws.

The purpose of these proposed revisions is to: (1) clean up existing regulations and update for recently enacted legislation; (2) add specificity and greater detail about the document accessibility standards and clarify procedural requirements for policy submissions; (3) clarify existing procedures for hospitals to follow in the policy review and patient complaint investigation processes; (4) clarify requirements for hospitals with consolidated licenses or distinct parts and add a process for hospitals to request modifications to the regulatory requirements; (5) modify the extension request process and hospital response time frames; (6) narrow the posting and website requirements to improve clarity and effectiveness; (7) clarify and expand existing requirements about policy effective dates, medical necessity, patient documentation, financial assistance applications, and hospital appeals; (8) identify and clarify base penalty adjustment factors for penalty assessments; and (9) improve readability and plain language and would also include stylistic, grammatical, and minor, non-substantive changes to existing regulation text.

III. BENEFITS OF THIS REGULATORY ACTION

The specific benefits anticipated from the regulatory action are simplified and improved plain language, better readability and organization, alignment with the current configuration and operation of the Hospital Fair Billing Program, and increased clarity and specificity to avoid confusion among the regulated public about compliance requirements and the Department's administrative processes. A hospital's ability to comply with the Hospital Fair Pricing Act, policy review process, and patient complaint investigations is important to the health and welfare of California residents, and it is crucially important that the compliance requirements and administrative penalty assessments are not confusing or ambiguous.

IV. PROBLEM, PURPOSE, AND NECESSITY OF EACH PROPOSED REGULATION

Article 1

Title: The title is amended to "General Provisions," for simplification since the existing title is a list of the section titles, which is cumbersome and restrictive. New sections are being added and others moved to different articles, so the new title is necessary for consistency and clarity.

Section 96051

Subdivision (a): New subdivision (a) adds the definition of “accessible portable document format.” Existing regulations on document accessibility and document formatting requirements are being strengthened in the proposed amendments and this definition is necessary to define terms used in the proposed language and clarify that documents need to be formatted to work with assistive technologies.

Subdivision (b): Existing subdivision (a) is renumbered to (b) as a result of the amendment above. The text is also amended to clarify that the “Act” is the Hospital Fair Pricing Act, since the Health and Safety Code does not refer to the specific act name, but the name is frequently used by the Department in correspondence to hospitals.

Subdivision (c): Existing subdivision (b) is renumbered to (c) as a result of the amendment above. Existing text remains unchanged.

Subdivision (d): New subdivision (d) adds the definition of “document” so repetitive text throughout the regulations can be consolidated or removed. Existing regulations outline the formatting requirements for documents and postings separately. By defining documents to include postings, the formatting requirements only need to be listed once, and it is made clear that those requirements also apply to the postings. Webpages have separate formatting and content requirements, so it is further clarified that “document” does not include webpages to avoid confusion over whether the document standards apply to websites as well.

Subdivision (e): Existing section 96051.25(b) is moved and renumbered to (e) so all definitions appear in the “definitions” section for better organization. The definition is also amended to make it more concise to improve readability.

Subdivision (f): New subdivision (f) adds the definition of “patient complaint portal” so the term does not need to be repeatedly explained in other sections.

Subdivision (g): New subdivision (g) adds the definition of “plain language.” Existing section 96051.1(a)(3) requires documents to use “plain, straightforward language that avoids technical jargon.” In practice, this is a broad standard to apply to policy compliance reviews. The Department looked at how other departments and agencies define “plain language” and are mirroring the definition used by the Department of Water Resources in Title 23, California Code of Regulations (CCR) section 351(w), as it was the most comprehensive and clear. Adding a specific, more detailed definition for “plain language” adds clarity and a more measurable standard for hospitals to comply with.

Subdivision (h): Existing subdivision (c) is renumbered to (h) as a result of the amendments above and is amended to only describe the various types of policies included in the Hospital Fair Pricing Act. The existing definition includes financial assistance applications in the definition of “policy,” which creates incompatible requirements in other sections that were meant to only apply to actual policies.

Subdivision (i): New subdivision (i) adds the definition of “policy submission.” Existing subdivision (c) (renumbered to (h)) was meant to provide a single term to encompass all documents required to be submitted to the Department. However, as described above, using “policy” alone creates confusion and inconsistencies related to the financial assistance applications. Separating the terms “policy” and “policy submission” adds clarity, specificity, and avoids confusion. The definition also clarifies that policy revisions are also covered by the term to avoid repetitiveness in later sections.

Subdivision (j): New subdivision (j) adds the definition for “policy submission portal.” Including this term in the definition section avoids having to repeat the web address in multiple sections, reducing redundancy.

Subdivision (k): Existing section 96051.6(b)(2) is moved and renumbered to (k) so all definitions appear in the “definitions” section for better organization. The existing definition is amended to remove “for the purposes of this section,” since moving the definition to the definitions section makes it applicable to the whole chapter.

Subdivision (l): Existing section 96051.6(b)(5) is moved and renumbered to (l) so all definitions appear in the “definitions” section for better organization. The existing definition is amended to remove “as utilized in Health and Safety Code section 127435 and for the purposes of this chapter” as this is unnecessary language.

Subdivision (m): Existing section 96051.7(a)(1) is moved and renumbered to (m) so all definitions appear in the “definitions” section for better organization. The existing definition is amended to remove “for the purposes of this section,” since moving the definition to the definitions section makes it applicable to the whole chapter.

Subdivision (n): Existing subdivision (d) is renumbered to (n) as a result of the amendments above. The words, “but shall not include State Holidays” is amended to “excluding State holidays” for simplification and clarity.

Notes: The reference citations in the note section are amended to add Health and Safety Code sections 127405, 127410, and 127425 to account for the definitions that were moved from other sections.

Section 96051.1

Title: The existing title is amended to “Accessibility and Readability Standards,” to better describe the contents of the section. In addition to the document accessibility standards, this section discusses the language requirements and tagline sheet which are “accessibility” standards, but not “document accessibility” standards.

Subdivision (a): Existing subdivision (a) is amended to include the plain language requirement from existing subdivision (a)(3), which is now defined in the definition section, so the paragraphs within subdivision (a) can be tailored to focus only on formatting requirements for better organization and transition language is rephrased for clarity. As a result, existing subdivision (a)(3) is repealed.

Subdivision (a)(1): Existing subdivision (a)(1) is repealed and to be replaced with specific requirements. The existing requirement that documents "be designed and presented in a way that is easy to read and understand by a patient" was meant to broadly encompass document accessibility requirements, which requires documents to be designed and presented in way that is easy to read and understand by a patient using assistive technology. Many hospitals have requested guidance on document accessibility, so specific measurable standards will be defined for the most common accessibility issues for Portable Document Format (PDF) files to make it easier for hospitals to comply with this requirement. In outlining the standards, the Department reviewed accessibility standards used by other agencies, such as Title 2, CCR section 1181.3 (which much of the amended text is modeled after); Department of Rehabilitation Document Accessibility Standards; and the Web Content Accessibility Guidelines version 2.2 (WCAG 2.2) and PDF Techniques for WCAG 2.0 developed by the World Wide Web Consortium (W3C).

Existing subdivision (a)(2) is renumbered to (a)(1) as a result of the amendment above and amended to match the new introductory transition language. Existing language requires 12-point size font in general and does not differentiate between body text and header/footer text, making any font that is not at least 12-point size noncompliant. The Department understands that font in headers and footers is typically smaller than body text, so to narrow the requirement, language is added to allow header and footer font to be 9-point size based on Section 508 guidance. Existing text about headers is moved to new subdivision (a)(5)(A); see below for details.

Subdivision (a)(2): New subdivision (a)(2) prohibits the use of justified alignment. This requirement is based on WCAG 2.2 success criterion 1.4.8 for successful visual presentation. Justified alignment stretches and compresses the space between words so text is flush with both the right and left margin. This can produce readability and tracking issues because extra space between words makes it difficult to follow text in one line and less space makes it difficult to distinguish words.

Subdivision (a)(3): New subdivision (a)(3) requires black text on white background whenever possible and prohibits use of color without additional distinguishing marks to emphasize or convey information. This is an amendment of the posting requirement in existing section 96051.10(a)(2), requiring postings "use a white background and black text." As mentioned previously, to avoid repetitiveness, the formatting requirements for documents and postings will now be combined to the requirements listed in this section. However, applying the white background and black text requirement to all documents is also warranted as the Department has reviewed policies from hospitals that use grey colored text throughout. When a watermark is also applied to the document, this grey text becomes difficult to read. In addition, there are color contrast requirements for document accessibility. Requiring black text whenever possible will eliminate the burden on the Department having to measure the color contrast of each hospital document submitted. The added requirement that additional distinguishing marks must be used if color is used to emphasize or convey information is based on WCAG 2.2 success criterion 1.4.1. Additional distinguishing marks provide an alternative way to differentiate

important information so that people who cannot see color and computer reading programs for the sight impaired can also discern that information.

Subdivision (a)(4): New subdivision (a)(4) requires lists to use bullet points, numbering, or an ordered list. When hospital policies do not use bullets, it can be hard to differentiate between text that is part of a list and a separate statement. WCAG 2.2 success criterion 1.3.1, requires that "Information, structure, and relationships conveyed through presentation can be programmatically determined or are available in text." Structuring lists using a format such as bullet points or numbering allows accessibility software to programmatically determine how to correctly read the items in the list.

Subdivision (a)(5): New subdivision (a)(5) requires headings to be formatted using the built-in heading styles to identify the headings' correct order of diminishing hierarchy. This is consistent with WCAG 2.2 success criterion 1.3.1, requiring that "Information, structure, and relationships conveyed through presentation can be programmatically determined or are available in text." Headings describe the topic, communicate the organization of the content on the page, and can be used by assistive technologies to provide in-page navigation. Headings that are assigned by their relationship to one another and presented in a logical (sequential) order provide structural context and make it easier to navigate and search through a document. Assistive technology users can access the list of headings and use it to "skim" through the content and go directly to areas of interest, which significantly speeds interaction for users who would otherwise access the content slowly.

Subdivision (a)(5)(A): The heading font and style requirement from existing (a)(2) is moved and renumbered to (a)(5)(A) to keep the heading requirements together. Existing text is amended to remove unnecessary language to be more concise.

Subdivision (a)(5)(B): New subdivision (a)(5)(B) requires the first heading in a document to be a Heading 1 and limits the use of one Heading 1 per document. Heading 1 is usually a document title or the main content heading and should therefore be the first heading in a document. Although there is not a specific WCAG requirement that there only be one Heading 1 per document, this is a best practice since it is the most important heading rank. This provision is necessary to ensure all hospital documents are structured the same. It is also clarified that more than one Heading 1 is acceptable when multiple documents are merged into a single file. This is necessary so hospitals understand how the requirement applies to merged documents submitted to the Department.

Subdivision (a)(6): New subdivision (a)(6) prohibits the use of "hard returns," which is a line break created by pressing the Enter key to create blank spaces between lines of text. It is a common issue encountered in hospital policies and using a hard return in these instances can create issues for accessibility software to understand how lines and paragraphs are meant to be read. Every hard return in a document is interpreted by assistive technologies as meaningful and will be read aloud to the person using the

assistive device as “blank,” which interrupts reading flow. This can easily be avoided by using styles formatting to apply spacing between parts of the document instead.

Subdivision (a)(7): New subdivision (a)(7) requires columns to be formatted using the word processing software’s columns function to ensure that screen readers are able to understand the correct reading order of the columns. WCAG 2.2 success criterion 1.3.2 requires that “When the sequence in which content is presented affects its meaning, a correct reading sequence can be programmatically determined.” Text is typically read from left to right, which could be problematic if a column structure is not correctly identified.

Subdivision (a)(8): New subdivision (a)(8) sets table formatting requirements, which are meant to ensure tables are compliant with WCAG 2.2 success criterion 1.3.1, requiring that “Information, structure, and relationships conveyed through presentation can be programmatically determined or are available in text.” Simple tables without split or merged cells where rows are not split across multiple pages are easier to navigate using keyboard shortcuts or assistive technology. Table header rows make it easier to navigate a table and for readers to understand what they are about to read. Tables should also only be used for presenting rows and columns of data, not to control layout (like creating columns or decorative boxes). Adding unnecessary table elements can confuse users of screen readers since the assistive technology announces table elements in a particular way.

Subdivision (a)(9): New subdivision (a)(9) requires images to include alternative text that describes the image or to be marked as decorative. The requirement to provide alternative text for any images is based on WCAG 2.2 success criterion 1.1.1 that “All non-text content that is presented to the user has a text alternative that serves the equivalent purpose.” Alternative text allows readers who cannot see the image to understand the purpose and meaning behind the image. Visual items like logos and non-text content that are pure decoration and used only for visual formatting must be marked as decorative so it will not be read aloud by assistive technologies.

Subdivision (a)(10): New subdivision (a)(10) requires that correct document structure tags are used, and that the information is presented in a logical reading order. This requirement is based on WCAG 2.2 success criterion 1.3.1, requiring that “Information, structure, and relationships conveyed through presentation can be programmatically determined or are available in text,” and success criterion 1.3.2, requiring “When the sequence in which content is presented affects its meaning, a correct reading sequence can be programmatically determined.” Document tags and reading order work together to ensure accessibility, with tags labeling the structure of the content and reading order determining the sequence in which the content is presented to a user through assistive technologies. They enable users with disabilities to access, navigate, and understand the content as intended. They are complementary requirements since a document with logical reading order, but inadequate tagging can be challenging for assistive technology users to navigate, and a well-tagged document can disorient users if its reading order is incorrect.

Subdivision (a)(11): New subdivision (a)(11) requires a descriptive title, that is not the same as the file name, to be included in the document properties. For document accessibility, both the document title and file name are important, but serve different purposes. The document title is the first thing a screen reader will read to the user and should provide a concise description of what the document is about. The file name is the name the user sees when the document is stored in a file system and helps identify the document when browsing through files. The Department is amending the regulations to include a specific file naming convention for the hospital policies and financial assistance application, which would not be appropriate for the document title. This provision is necessary because many of the documents submitted by hospitals for the 2024 biennial policy submission either did not have a document title, or included an obscure title that did not describe the document.

Subdivision (b): Existing subdivision (a)(4) is renumbered to (b) to separate the language requirements from the formatting requirements for better organization. Existing language requires that "all" documents "Meet the language requirements outline in Health and Safety Code section 127410(a)." To limit the number of documents that must be readily available in translated form, the requirement is amended from "all" to specifically the hospital policies, financial assistance application, and the notice required by Health and Safety Code section 127410(a), as these are the most important documents to notify patients of the availability of financial assistance. A patient who does not read English, may not know to ask for translated versions of those documents if they do not know what they are, and having them already translated ensures equal access to the information. Other documents, like the eligibility determination letters, could be translated upon request since at that point, the hospital will have communicated with the patient and will know whether translation services are needed. The language is also amended to outline the specific requirement rather than referencing only the Health and Safety Code section for clarity. Health and Safety Code section 127410(a) requires written correspondence to the patient "be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law." Insurance Code section 12693.30 requires written information to be provided in "each of the languages identified pursuant to Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code." Government Code sections 7295 and 7296.2 require written materials to be translated into any non-English language spoken by non-English-speaking individuals who make up 5% or more of the population served. Rather than making hospitals follow the statutory redirects and decipher what the Department is requiring, the requirement will be plainly stated.

Subdivision (c): Existing subdivision (b) is renumbered to (c) as a result of the amendment above. The internal section reference is updated to reflect the renumbered section and the repetitive restating of "Health and Safety Code" is eliminated. Existing language requires the tagline sheet include the verbatim statement included in the regulation, so the word "substantially" is being added to allow flexibility when the statement is altered but conveys the same information. The Department has seen instances where hospital tagline sheets have reordered the sentences of the statement,

or rephrased slightly, but not enough to alter the overall purpose of the statement. As a result, the tagline sheets are technically noncompliant with the existing requirements. That inflexibility was not the purpose of the requirement, which is to ensure patients are notified about how to obtain language assistance and alternative accessible formats.

In this subdivision and throughout the proposed amendments, the word "shall" is being replaced with "must" (or "will" in other sections) to promote plain language and clarity. Writing plainly means writing to be understood, using familiar language, in the simplest, most straightforward way. "Shall" is not used in common language in a person's everyday vocabulary, and because the meaning of "shall" depends on context, it can be interpreted to mean "may," "will," or "must," which can be confusing. Replacing "shall" with "must" or "will" is simpler, clearer, and avoids misinterpretation.

Section 96051.2

New section 96051.2 is added to clarify the requirements for hospitals that share a license with another hospital either on a consolidated license[2] or as a distinct part.[3]

Subdivision (a): New subdivision (a) adds that each physical plant maintained and operated on separate premises, under a single consolidated license or as a distinct part, is considered a separate hospital for purposes of the Act and this chapter. This is already implied by the law but is being made clearer. Health and Safety Code section 127400(d) defines a "hospital" as "a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Corrections and Rehabilitation." Fresno Heart and Surgical Hospital located at 15 E. Audubon Dr., Fresno, CA 93720, and Community Regional Medical Center located at 2823 Fresno St., Fresno, CA 93721, are on the same consolidated license. Fresno Heart and Surgical Hospital is a facility that is required to be listed under Health and Safety Code section 1250(a) and Community Regional Medical Center is also a facility that is required to be listed under Health and Safety Code section 1250(a). Being on the same license does not make the facilities the same hospital. The names are different, the locations are different, and from the general public's perspective, being admitted to Fresno Heart and Surgical Hospital is not the same as being admitted to Community Regional Medical Center. All hospitals on consolidated licenses or distinct parts that are on separate premises have already submitted policies to the Department, so this does not add any additional reporting requirements. However, the Department's interpretation of the law did receive resistance from hospitals, so this provision is necessary to explicitly clarify the definition of "hospital" to make the hospital obligations

[2] Under Health and Safety Code section 1250.8, a single consolidated license will be issued "to a general acute care hospital that includes more than one physical plant maintained and operated on separate premises."

[3] Title 22, California Code of Regulations section 70027 defines a "distinct part" as "an identifiable unit accommodating beds and related facilities including, but not limited to, contiguous rooms, a wing, floor or building that is approved by the Department for a specific purpose."

clear and to avoid confusion for any newly licensed hospitals that need to comply.

A distinction is being made for physical plants maintained and operated on *separate premises* (as the term is used in CDPH licensing standards). For example, when a distinct part acute psychiatric hospital is on the same premises, either in the same building as the general acute care hospital or in a neighboring building on the same medical campus, a person may not realize they are going to a different facility. A separate reporting requirement for physical plants on the same premises is not necessary because physical plants on the same premises will have the same office for financial assistance information, the same billing office, wall postings in the same locations, and will essentially be the same for Department and patient purposes.

Subdivision (b): New subdivision (b) is added to make it explicitly clear that each physical plant must comply with the Act and this chapter. As described above, each separate physical plant is a “hospital” in its own right. Regardless of being on the same license, each hospital must have the required wall postings at each location. Using the example above, having wall postings at Fresno Heart and Surgical Hospital would not exempt Community Regional Medical Center from also having the required wall postings. Each location must hand out the notices required by Health and Safety Code section 127410(a) to patients receiving services. Each location likely has a designated office *within* that facility where patients can submit financial assistance applications or go for more information. The Hospital Fair Pricing Act is about the required actions of the *hospital*, not the licensee, because each *hospital* is separate and responsible for complying with the laws.

Subdivision (c): New subdivision (c) makes clear that compliance history for penalty assessments will be specific to the physical plant location, not the license. Again, using the example above, a patient filing a complaint about a bill from Community Regional Medical Center, is not complaining about Fresno Heart and Surgical Hospital. Because they are separate hospitals, any compliance history when considering penalty adjustment factors will be based on the history of the specific hospital, not all hospitals on the same license. It would be unfair if a more compliant hospital had to receive a higher penalty because its license counterpart had received more penalty assessments.

Section 96051.3

New section 96051.3 is added to establish a procedure for hospitals to request a modification to the regulatory requirements.

Subdivision (a): New subdivision (a) allows the Department to grant a modification to the regulatory requirements upon written request. Since the existing regulations became effective, hospitals have inquired about modifications to the requirements. For example, hospitals have asked to use electronic postings and communications, or county hospitals have had difficulty complying with website requirements since they do not control the county website. Allowing for modification requests will allow hospitals to comply in alternative ways that do not diminish the regulatory purpose. Since the

modification will be deviating from the regulatory requirement, a written request is necessary for documentation purposes to create a record of the requested change.

Subdivision (b): New subdivision (b) requires the modification request to state the specific changes being requested and the reason(s) the changes are needed. This is necessary so the Department can effectively evaluate the request and the necessity for the modification. It also provides a detailed record of the specific change. To avoid a penalty for failing to comply with a requirement, a hospital will need documented proof of the approved modifications.

Subdivision (c): New subdivision (c) requires hospitals to have Department approval prior to implementation of any changes to the applicable requirements. Since the modifications are a deviation from the regulatory requirements, this provision is necessary to ensure hospitals will not seek approval after the fact, which would make the violation intentional. A penalty for failure to comply with the regulatory requirements can only be avoided if the modification was approved prior to the change.

Section 96051.4

Existing section 96051.4 remains unchanged.

Article 2

Title: The existing title is amended to “Hospital Fair Pricing Policies,” to simplify and shorten the title for better readability. “Hospital Fair Pricing Policies” encompasses the policies currently listed in the title.

Section 96051.5

Title: The existing title is amended to “Contact Registration” to be more concise and less repetitive. This also mirrors how regulations for other units within the Department are phrased and structured.

Subdivision (a): Existing subdivision (a) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). The second sentence is deleted and combined with the first since the implied purpose of having two contacts is so an alternate person is available if the first contact is not. “Receiving” is replaced with “submitting required documents and receiving time-sensitive” communications to better reflect the hospital contacts’ duties since the contacts are responsible for submitting required documents in addition to receiving communications from the Department. “Time-sensitive” is added to stress and make clear that many of the Department communications have a deadline to respond and the contact needs to be a person who is available to respond in a timely manner so hospitals can designate contacts accordingly.

Subdivision (b): Existing subdivision (b) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). To streamline

and reduce repetitiveness, the unnecessary word, “online,” is removed since electronic portals are online, and the web address is removed since it is now stated in the definitions section.

Subdivision (b)(1): Existing subdivision (b)(1) remains unchanged.

Subdivision (b)(2): Existing subdivision (b)(2) is amended to eliminate awkward phrasing and match the phrasing of subdivision (b). If the primary and secondary contacts are registering themselves, they are providing their own name.

Subdivision (b)(3): Existing subdivision (b)(3) is amended to eliminate awkward phrasing and match the phrasing of subdivision (b). If the primary and secondary contacts are registering themselves, they are providing their own business title.

Subdivision (b)(4): Existing subdivision (b)(4) is repealed as it is unnecessary and does not reflect the current practices and needs of the Department. All communications are sent to hospital contacts through the policy submission portal, and administrative penalty notices are sent via certified mail to the licensee and hospital addresses on file with CDPH. An address for the hospital contact is not needed.

Existing subdivision (b)(5) is renumbered to (b)(4) as a result of the amendment above and amended to add the word “address” for consistency. “Email address” as opposed to just “email” is used in all other sections. This is a non-substantive change.

Subdivision (b)(5): Existing subdivision (b)(6) is renumbered to (b)(5) as a result of the amendment above and amended to require a “direct” business phone number. The hospital contacts are meant to be the liaison between the hospital and the Department for communications. Contact information is requested so the Department can reach a specific person when needed, however, the Department has experienced instances where a direct phone number was not provided, which made getting in contact with the designated person more difficult.

Subdivision (b)(6): Existing subdivision (b)(7) is renumbered to (b)(6) as a result of the amendment above and amended to match the phrasing of the previous subdivisions. This is a non-substantive change.

Subdivision (c): Existing subdivision (c) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Unnecessary words and references are also removed for simplification.

Section 96051.6

Existing section 96051.6 covers a multitude of topics under the subject title of “Hospital Policies” which makes the information within hard to intuitively find based on section titles alone. This section is now divided into separate sections to be clearer and mirror the regulation structure of other units within the Department that also have reporting requirements.

Title: The existing title is amended to “Due Dates,” and this section will now only cover that topic.

Intro: Language is added to introduce the various reporting deadlines that follow.

Subdivision (a): Existing subdivisions (a)(1) to (a)(3) are repealed. Effective dates will be addressed in new section 96051.10, and existing subdivisions (a)(2) and (a)(3) are unnecessary as they are a non-exhaustive list of the substantive policy requirements and are duplicative of the statutory requirements since they only require compliance with the law and do not clarify, interpret, or make those laws more specific.

Existing subdivision (b) is repealed as it is no longer necessary since policy submission requirements are covered in section 96051.7.

Existing subdivision (b)(1) is renumbered to (a) as a result of the amendments above and reduced to only the biennial deadline to remove redundant information or information that will be addressed in another section for better organization and clarity.

Subdivision (b): Existing subdivision (b)(2) is moved and renumbered to section 96051(k) (discussed above). Existing subdivision (b)(3) is renumbered to (b) as a result of the amendment above. The language is reordered to match the introductory language and amended to be more concise. Language is also added to apply a deadline for when hospitals that are newly acquired under an approved change of ownership must submit policies. Without this language, a hospital that changed owners would not be required to submit updated documents to the Department until the biennial reporting period or after it made a significant change to the policies previously submitted to the Department. This could result in an incorrect or outdated policy being published on the Department’s website for that hospital. Ten calendar days is a reasonable amount of time for a new owner to submit an updated policy. The process of changing owners takes a significant amount of time to arrange sale agreements, apply for the change of ownership approval with CDPH, and for CDPH to make a decision. The new owner can prepare the required policies and application during that time. In addition, a hospital does not usually close during the change of ownership process, and once it becomes effective, the policies need to be available to both the Department and patients.

Subdivision (c): Existing subdivision (b)(4) is renumbered to (c) as a result of the amendment above. Existing text does not include a deadline for when hospitals are required to submit policies after making a significant change. Existing text only states that policies submitted due to a significant change must be submitted through the policy submission portal, which is already established and does not need to be repeated. The text is amended to require hospitals to submit policies within 10 calendar days of the effective date on the policy when a significant change is made voluntarily by the hospital. This creates a measurable standard for the Department to determine whether a significant change was reported timely. Ten days is a reasonable amount of time because the hospital will have already made the change before reporting it to the Department. This is just setting a deadline for how quickly the hospital then needs to

submit the updated policy to the Department so the most current version in effect can be published on the Department's website.

Subdivision (d): New subdivision (d) is added to set a deadline for hospitals to submit a significant change after a new statutory or regulatory requirement goes into effect, if a significant change is needed to maintain compliance. The legislative and rulemaking processes take place the year before a statute or regulation will become effective. Hospitals have a duty to be aware of the laws and regulations they must comply with and will therefore have several months' advanced notice of an approved statute or regulation before it becomes effective. Thirty calendar days from the effective date allows sufficient time for hospitals to submit a significant change and limit the amount of time the policy may be noncompliant.

Existing subdivision (b)(5) is moved and renumbered to section 96051(l) (discussed above). Existing subdivisions (b)(6), (c) and (d) are moved and renumbered as a result of the division of section 96051.6 and discussed below.

Section 96051.7

Existing sections 96051.6(b)(6) and (c) are moved and renumbered to section 96051.7 as a result of the division of section 96051.6.

Subdivision (a): New subdivision (a) establishes that policy submissions or reports of no significant change must be made through the Department's policy submission portal. This language was removed from existing section 96051.6(b)(1), as stating it once here in the new "Submissions Requirements" section is more organized and eliminates the need to repeatedly state how and where documents are submitted to the Department.

Subdivision (b): Existing section 96051.6(b)(6) is moved and renumbered to 96051.7(b) as a result of the division of section 96051.6. The word, "shall," is amended to "must." (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (b)(1): Existing section 96051.6(b)(6)(A) is moved and renumbered to 96051.7(b)(1) as a result of the division of section 96051.6. "Most recent" is added to clarify which effective date needs to be identified with the policy submission. Many hospitals are providing the original effective date of when the policy was first written instead of the effective date of the version of the policy being submitted. This clarification will help prevent the Department from having to manually fix these dates.

Subdivision (b)(2): Existing section 96051.6(b)(6)(B) is repealed as it does not reflect the Department's current process. The regulations were originally drafted before the systems were built for policy submissions. The Department originally intended for hospitals that are part of a network where multiple hospitals use the identical policy to be able to submit one policy submission that would apply to all the hospitals listed. However, this function was not built into the current system being used and the requirement needs to be removed so the regulation conforms to the actual practices.

Existing section 96051.6(b)(6)(C) is moved and renumbered to 96051.7(b)(2) as a result of the division of section 96051.6 and the amendment above. The certification requirement is amended to reference Code of Civil Procedure section 2015.5 to ensure compliance with the law and eliminate the need to explicitly state what the certification must include.

Subdivision (c): Existing section 96051.6(c) is moved and renumbered to 96051.7(c) as a result of the division of section 96051.6. Existing text remains unchanged.

Subdivision (c)(1): Existing subdivisions (c)(1) and (c)(2) are being combined into (c)(1) for simplification, and the language is amended to be more concise and direct. The requirement that documents be in a "machine readable format" is removed because that is incorrect terminology for what the Department intended and is amended to require the PDF files to be searchable, text-based, and accessible. The requirement that the PDF files be unlocked is also added because the Department needs to be able to highlight or add notes when reviewing for compliance, which is not possible to do electronically if the PDF is password protected. "Should" is also amended to "must" because "should" implies a suggestion while "must" implies a requirement. If the documents must be text-based, it means they must not be imaged-based (i.e., scanned versions or images of paper documents).

Subdivision (c)(2): Existing section 96051.6(c)(3) is moved and renumbered to 96051.7(c)(2) as a result of the division of section 96051.6 and further broken into (c)(2)(A) and (c)(2)(B). Text is amended to be more concise and use amended definitions.

Subdivision (c)(2)(A): New subdivision (c)(2)(A) clarifies the requirement for the "clean version" of the documents. Documents submitted by the hospitals through the policy submission portal are automatically posted on the Department's website as submitted. Although it seems implied that the "clean version" should be free from mark-ups, "draft" watermarks, and coversheets, many hospitals have not understood this, necessitating the need for clarification.

Subdivision (c)(2)(B): New subdivision (c)(2)(B) is amended to adjust the phrasing to the new structure, remove unnecessary words, and align with the new definitions. The word "any" is replaced with "only" to clarify and make clearer what changes must be illustrated in the marked-up version. The purpose of this requirement has always been for the marked-up version to only include illustrations of changes since the policy was last submitted to the Department. However, when asking for multiple revisions during the policy review process, most of the hospitals failed to include only the changes since the last submission and instead showed all changes since the initial submission. The purpose of the marked-up version is so the Department can easily identify new language that has not yet been reviewed for compliance and quickly review changes made in response to corrective actions requests. When the marked-up version contains underline and strikethrough text that has already been reviewed, time is wasted

reviewing that language again and it takes more time for the Department to determine which changes are new.

Subdivision (c)(3): New subdivision (c)(3) is added to include a file naming convention for the submitted documents. As stated previously, the documents submitted by hospitals are automatically posted on the Department's website as submitted. If a hospital uses an obscure file name, this is the file name that appears when a person downloads the file from the Department's website. This is also the file name that appears when the Department is downloading all the hospital documents from the policy submission portal to perform the policy review. When the file name does not clearly identify what the document is, keeping track of the files can be difficult and it may not be readily apparent that a wrong document was submitted.

Subdivision (c)(3)(A): New subdivision (c)(3)(A) is added to identify a specific naming convention so all hospitals will have consistently named files. The acronym of the hospital name is used so the file names do not become too lengthy and avoid character limit errors. The document type is necessary so a person can tell by the file name what the file is. And the submission date in the file name is necessary to keep track of the different versions when hospitals need to submit revised documents to correct violations identified by the Department.

Subdivision (c)(3)(B): New subdivision (c)(3)(B) is added to ensure consistency in the naming convention. Hospitals use different names for their policies like "MFA Policy," "Self-Pay Discount Policy," "Uninsured Discount Payment Policy," "Charity Care and Partial Charity Care Policy." Standardizing the names of the document types will add clarity, consistency, simplicity, and help ensure the correct documents are being submitted to the Department.

Subdivision (c)(3)(C): New subdivision (c)(3)(C) is added so there is a standardized way to identify the files of the marked-up versions. Having a specific file name for the marked-up version will also help prevent hospitals from just submitting a duplicate copy of the clean version.

Subdivision (c)(4): New subdivision (c)(4) is added to ensure policy files include all referenced attachments or appendices in one combined file. Many policies refer to attachments/appendices, but not all hospitals include them in the submission. In those cases, the Department then must request a copy of the documents, which the hospital has 30 days to provide, and the policy review process is unnecessarily delayed. Frequently, those attachments/appendices contain important information like tables of the specific percentage discount a patient is eligible for. Under Health and Safety Code section 127435, a patient cannot be denied financial assistance that would be available pursuant to the policy published on the Department's website at the time the patient was first billed. Under Health and Safety Code section 127436, the Department must review a patient's eligibility for financial assistance in patient complaints under the hospital's published financial assistance policy in effect at the time the patient was first billed.

Determining a hospital's compliance with these requirements requires having the complete policy.

Subdivision (c)(5): New subdivision (c)(5) is added to streamline the documents submitted. Many hospitals include the financial assistance application as an attachment to the financial assistance policy, and rather than providing the application as a standalone document, the hospital will provide a copy of the financial assistance policy with attachments twice, uploading the same file for the financial assistance policy and the financial assistance application. When patients are downloading a copy of the hospital's financial assistance application from the Department's website, it is more beneficial for them to be able to download and print just the application since the financial assistance policy is already available separately.

Section 96051.8

Existing section 96051.6(d) is moved and renumbered to section 96051.8 as a result of the division of section 96051.6. The section is also expanded to clarify the policy review process to more accurately reflect the current configuration and operation of the Hospital Fair Billing Program and to mirror the language and structuring used in the regulations for the complaint review process.

Subdivision (a): New subdivision (a) is added to clarify that the Department may request additional information, including copies of documents, from the hospital at any time during the policy review process. This mirrors the language in the complaint review process regulations.

Subdivision (a)(1): Existing section 96051.6(d)(1) is moved and renumbered to 96051.8(a)(1) as a result of the division and restructuring of section 96051.6. Existing language gives the hospital 30 calendar days to respond to *any* correspondence from the Department. This timeframe was originally selected to encompass responses to requests for information and responses to requests for policy revisions. In practice, allowing 30 calendar days for any response has greatly extended the policy review process and it is more efficient to assign separate timeframes for providing additional information versus providing revisions. When the Department requests additional information, it is for documents that were not provided and should be readily available to send to the Department (like policy attachments), or information that should already be known (like what languages the hospital's documents are currently translated into). A shorter timeframe for these types of requests will reduce unnecessary delays and allow the Department to complete the compliance review faster. Hospitals are not burdened by this shortened timeframe since the Department is only requesting copies of documents that already exist and information that should not take 30 calendar days to provide. Based on the requests for additional information that were sent during the 2024 biennial policy review, hospitals provided responses within 14 days or less about 40 percent of the time. Thirteen percent of the hospital responses were received the same day or the next day.

Subdivision (a)(2): Existing section 96051.6(d)(2) is moved and renumbered to 96051.8(a)(2) as a result of the division and restructuring of section 96051.6. Existing language only requires that responses be "complete," which is obvious and unnecessary. The phrasing of a "complete response" has been added to subdivision (a)(1) and this subdivision is amended to clarify what happens when a response is not complete. A hospital's response may be incomplete because a wrong document was provided or not all the questions were answered. Providing something that was previously requested should not be subject to a new response deadline because this adds further delay to the process and would allow hospitals to extend deadlines (and possibly avoid late penalties) by providing incomplete responses.

Existing section 96051.6(d)(3) is repealed since it is no longer necessary. The definitions clarify that policy submissions include revised policy submissions, meaning the "submission requirements" apply to revisions as well and do not need to be repeated.

Subdivision (b): New subdivision (b) is added to mirror the language and structuring used in the regulations for the complaint review process and clarify the policy review process. This subdivision is necessary to introduce the steps of the review process and ensure it is clear that hospitals will be notified of a compliance determination after all relevant information is reviewed.

Subdivision (b)(1): New subdivision (b)(1) is added to inform hospitals that if violations are found during the compliance review, an initial compliance determination will be issued to the hospital detailing the findings. This informational provision is necessary to clarify what action the Department will take after making an initial compliance determination so the hospital knows what to expect.

Subdivision (b)(2): New subdivision (b)(2) is added to reincorporate the 30-calendar day deadline that was removed from subdivision (a)(1) above. Language is added to clarify that a hospital will have 30 calendar days after issuance of the initial compliance determination to correct the identified violations and submit revised policies.

Subdivision (b)(3): New subdivision (b)(3) is added to clarify the policy review process. The added language explains that revised policies will be reviewed, the Department's compliance determination will be updated, and the hospital will be provided with another opportunity to correct the outstanding violations. This is necessary so the hospital is aware that more than one opportunity to correct the violations will be provided before an administrative penalty is assessed.

Subdivision (c): New subdivision (c) is added to address how and when a final compliance determination and penalty assessment will be made. This is necessary to make clear that an initial compliance determination is not a penalty assessment, it is not the final step in the process, and it is not ripe for appeal.

Subdivision (d): New subdivision (d) is added to clarify what actions the hospital is required to take after an administrative penalty notice has been issued or after an appeal decision has been rendered.

Subdivision (d)(1): New subdivision (d)(1) is added to set a deadline for violations that were not corrected during the policy review process. This is necessary to ensure that the correction is made timely after an administrative penalty assessment has been issued or upheld after appeal.

Subdivision (d)(2): New subdivision (d)(2) is added to mirror the language in the complaint review process regulations on when penalties are expected to be paid to the Department, so it is clear the same deadline applies for penalties assessed during the policy review process.

Section 96051.9

Existing sections 96051.6(d)(4) to (d)(6) are moved and renumbered to section 96051.9 as a result of the division of section 96051.6.

Subdivision (a): Existing section 96051.6(d)(4) is moved and renumbered to section 96051.9(a) as a result of the division of section 96051.6. Language is amended to improve specificity and be more concise. Language requiring hospitals to “describe the actions being taken to obtain the information or records and when receipt is expected” is removed because the extension request process will now be automated, so the language is no longer applicable. Reviewing and responding to extension requests is time consuming and automating the process will eliminate that burden.

Subdivision (b): New subdivision (b) is added to provide a separate extension period for responses to requests for information. An additional 14 calendar days is sufficient as that puts the timeframe close to the existing 30 calendar days, and a majority of the hospitals have responded to requests for information within the existing 30 calendar day timeframe. Based on the requests for additional information that were sent during the 2024 biennial policy review, hospitals provided responses within 30 days or less 72 percent of the time. A cap on the number of extensions and the total amount of time allowed is being added to prevent multiple requests from extending the process. In this age of technology, there is no reason why one of the two hospital contacts cannot provide the Department with an electronic file of a document that already exists within 30 days. In addition, almost all the designated hospital contacts currently registered with the Department are the hospital’s directors and upper executives of the hospital’s financial assistance programs. As the person most knowledgeable, those contacts should be capable of answering any clarifying questions about the hospital’s policies within 30 days or less.

Subdivision (c): New subdivision (c) is added to address extensions specifically for policy revisions in response to a corrective action request. Currently, there is no limit on how many extensions can be requested, which has greatly extended the policy review process. To help limit this, a cap on the number of extensions and the total amount of

time allowed is being added. A vast majority of the extension requests received were to account for the hospitals' board of directors meeting schedules. The Department understands that these meetings are on a set schedule, and board approval is needed for hospital policy changes. To accommodate this, the extensions being allowed are still quite generous. For each revision, hospitals will be granted up to two extensions, not to exceed an accumulated total of 90 calendar days (60 days for the first request, and an additional 30 days for the second). Based on the Department's experience, with the 30 calendar days the hospital is already provided, 120 days is more than enough time to make revisions and account for board meeting schedules. During the 2024 biennial review, when a hospital was asked by the Department to revise its policies after the Department's initial compliance determination, hospitals needed an average of an additional 22 days to submit revised policies, 31 percent of the hospitals did not require an extension at all, and only two hospitals required more than a 90-day extension. Of the hospitals that submitted more than one policy revision, 75 percent did not require an extension for those subsequent revisions.

Existing section 96051.6(d)(5) is repealed in its entirety. Since the extension request system will be fully automated with the limited number of extensions automatically granted, the reasons for the extension requests no longer need to be considered. Removing this text is necessary to align with the process being used.

Subdivision (d): Existing section 96051.6(d)(6) is moved and renumbered to section 96051.9(d) as a result of the division of section 96051.6. Unnecessary language is removed to be more concise.

Section 96051.10

This new section is added to provide additional clarity on effective dates, particularly where revision submissions are concerned.

Subdivision (a): New subdivision (a) is an amendment of existing section 96051.1(a)(1) that was moved and renumbered to 96051.10(a) as a result of the division of section 96051.6. The amended language makes clearer that the effective date must state the date "the version of the policy submitted" went into or will go into effect at the hospital. When policies are revised, there should be a date to indicate when that revision went into effect. Only listing when the policy originally went into effect makes it hard to keep track of the various versions posted on the Department's website and identify the most current version.

Subdivision (b): New subdivision (b) is added to clarify when an effective date may remain unchanged. When a hospital is only making formatting changes to its policy (like fixing font size or document accessibility), the effective date does not need to be updated because the content of the policy is not changing. But when there are changes other than formatting, then an updated effective date is required. This is because the hospital's policies are posted on the Department's website as soon as received. If the hospital changes noncompliant language to correct a violation, that newer version cannot retroactively replace the version already posted on the Department's website

since whatever is posted on the website at time of billing controls under Health and Safety Code sections 127435 and 127436. The previous version is in effect until the next version is posted online, both versions are posted, and both need different effective dates since they are not the same policy.

Section 96051.11

Existing section 96051.7 is renumbered to 96051.11 as a result of the amendments above.

Existing section 96051.7 covers several different topics under the title, “Discount Payment Program.” However, as a result of AB 2297, all the topics are no longer exclusive to only discount payment, which would make this section misleading. To correct this issue, existing section 96051.7 will be divided into multiple sections.

Title: This existing title is amended to “Medical Necessity” to describe the first topic covered.

Subdivision (a): Existing subdivision (a) is divided into subdivision (a) and (b). The first sentence of the existing text is amended to remove unnecessary language to be more concise and the text after the first sentence is moved to new subdivision (b) for better organization.

Subdivision (a)(1): New subdivision (a)(1) is added to address a loophole that was created by requiring all medical necessary services be eligible for discount payment. Existing language could allow patients with health coverage to circumvent their network and receive out-of-network care that is not covered by a third-party payer at a discounted rate, at a cost to the hospital. Hospitals can prevent most of this through their admission procedures for non-emergency services but would have to provide discount payment for post-stabilization service after an emergency for patients who decline transfer to an in-network facility. The intent of the legislature is to ensure qualified individuals receive financial assistance, not to circumvent the laws and regulations that apply to third-party payer network requirements. To address this, language is added to make it optional whether a hospital provides discount payment in these situations.

Subdivision (b): New subdivision (b) is the second half of the existing text from subdivision (a) as described above. Existing text explains how medical necessity will be determined; however, this is not how it is determined in general. Language is added to make it clearer that this is how the Department will address medical necessity for patient complaint investigations. Unnecessary language is removed to be more concise and the word, “shall,” is amended to “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Existing subdivision (a)(1) is moved to the definitions section and renumbered to section 96051(m). (Discussed above). Existing subdivisions (b) through (e) are moved and renumbered as a result of the division of section 96051.7 and discussed below.

Section 96051.12

Existing section 96051.7(b) is moved and renumbered to new section 96051.12 as a result of the division of section 96051.7.

Subdivision (a): Existing section 96051.7(b) is moved and renumbered to 96051.12(a) as a result of the division of section 96051.7. Under AB 2297, documentation of income is now limited to recent tax returns or pay stubs for both discount payment and charity care (previously just discount payment). To conform to the new law and avoid confusion, the introductory language referencing only the discount payment program is removed. Eligibility is based on a patient's family income, so the word "family" is added for clarity since documentation is needed for all family members and not just the patient. Other minor grammatical changes are made and unnecessary language removed.

Subdivision (b): New subdivision (b) is added to clarify the time period for documentation of a patient's medical expenses. Under Health and Safety Code section 127400(g)(2), a patient can qualify as a "patient with high medical costs" if their annual out-of-pocket expenses exceed 10 percent of their family income based on documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. Many hospitals measure this time from 12 months prior to applying for financial assistance. However, under Health and Safety Code section 127405(e)(3), a patient can apply for financial assistance at any time, and under subdivision (a), income is based on the patient's income at the time of first billing. For consistency, expenses should be measured at the time of first billing or income and expenses may be based on different time periods creating inconsistent eligibility determinations.

Existing section 96051.7(c) is repealed as it is unnecessary. Health and Safety Code section 127425(i) is clear that an extended payment plan may be declared no longer operative after the patient fails to make all consecutive payments during a 90-day period. The 90-day period can only start after the first missed payment, and this does not need to be stated in the regulations.

Existing section 96051.7(d) is moved and renumbered to section 96051.18, so it appears in the article about notices for better organization and clarity.

Existing section 96051.7(e) is repealed as it is unnecessary. It is duplicative of Health and Safety Code section 127425(k).

Section 96051.13

Existing section 96051.8 is renumbered to 96051.13 as a result of the newly added sections.

Title: The existing title is amended to "Financial Assistance Applications" to be more concise.

Subdivision (a): Existing subdivision (a) is repealed in its entirety. Existing text identifies two issues that must be made clear on the application form when using a single application for both discount payment and charity care. Existing subdivision (a)(1) was previously amended with a non-substantive change after AB 2297 to conform to the new law, but it is now worded in a way that just repeats what is already stated in Health and Safety Code section 127405(e)(1). It is now being removed as it is unnecessary. AB 2297 also added definitions for "charity care" and "discount payment" in Health and Safety code section 127400.5. "Charity care" is now defined as "free care," and "discount payment" is "any charge for care that is reduced but not free." By the very definitions, discount payment will always provide less financial assistance than charity care, so the disclaimer in existing subdivision (a)(2) is no longer necessary is removed.

New subdivision (a) is added to alleviate the burden on patients from having to fill out overly complicated financial assistance applications. The Department has seen applications that contain 5-page tables requiring a detailed breakdown of income sources. When tax returns are required with the application, patients should not have to transcribe each line item from the tax return into the application. That is unnecessarily time consuming for the patient and could result in transcription errors that either the hospital must take time to double check or could result in an improper denial if unchecked. Complicated and lengthy applications can also deter patients from applying.

Subdivision (b): New subdivision (b) is added to require hospitals to use a single application for both discount payment and charity care. A single application is the most efficient way to ensure a patient can apply for both programs simultaneously, if desired, and avoid overlooking the charity care option because the patient was not aware there were separate applications. If the eligibility requirements for discount payment and charity care are different, the application must give the patient the option to apply for only discount payment because charity care can have more restrictive eligibility limitations. For example, to be eligible for charity care, a hospital could require that a patient apply for and be denied governmental assistance like Medicare or Medi-Cal. If a patient does not want to apply for those programs, they need to be able to apply for discount payment.

Article 3

Section 96051.14

Existing section 96051.9 is renumbered to 96051.14 as a result of the amendments above.

Title: The existing title, "Discharge Notice," is amended to "Financial Assistance Notice." This is to make the name more precise and avoid confusion with existing hospital notices. Under Health and Safety Code section 127410(b), the written notice required by 127410(a) must be provided at the time of service unless the patient is unconscious. If the patient is not able to receive notice at the time of service, it must be provided at discharge. If the patient leaves the facility without receiving the written notice, it must be mailed. Calling the notice a "discharge" notice is imprecise when that is one of three

ways the notice can be provided and is only an alternative if the patient is unconscious at the time of service. In addition, hospitals already provide patients with a “discharge summary” which is a clinical report summarizing a patient’s hospitalization, including diagnoses, treatments, and follow-up plans. Using a similar name has caused confusion when requesting a copy of the hospital’s discharge notice for patient complaint investigations. The notice is about the hospital's financial assistance programs, so calling it a “financial assistance notice” makes more sense.

Existing subdivision (a) is repealed in its entirety. Exiting subdivision (a)(1) is repealed to eliminate the hardcopy requirement because Hospitals have expressed to the Department the financial burden of this requirement since the notice must be provided to every patient for every separate hospital visit. The Department understands that many patients prefer electronic communication, electronic communications create a more reliable record of receipt for both patients and the hospital, and allowing electronic notice will reduce the number of notices printed and provided to patients who may have frequent hospital visits for on-going care. Existing subdivision (a)(2) is already covered by section 96051.1 which applies to “all hospital documents,” and is therefore repetitive. Existing subdivisions (3)(A) to (3)(E) are duplicative of Health and Safety Code section 127410(a) and unnecessary. Existing subdivisions (3)(F) and (3)(G) will be covered by the new sections 96051.19 and 96051.20, and do not need to be repeated here.

Existing subdivision (b) will be amended to remove the numbering since it will be the only text within section 96051.14. The text will be amended to focus the record requirement on only situations where a hardcopy notice is provided since notices sent electronically will have an automatic contemporaneous record due to the nature of electronic messaging. The text is also amended to separate the text into two sentences for grammatical clarity.

Section 96051.15

Existing section 96051.10 is renumbered to 96051.15 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to be more concise and improve readability. As part of the plain language efforts, “in accordance with” is replaced with “required by.” And “shall” is amended to “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Existing sections 96051.10(a)(1), (a)(2), (a)(4), and (a)(5) are repealed since they are addressed in section 96051.1 and unnecessarily repetitive.

Subdivision (a)(1): Existing subdivision (a)(3) is renumbered to (a)(1) as a result of the amendments above. Language is added to limit the posting to one sheet. The posting is meant to attract attention and notify patients about the availability of financial assistance and direct them to where more information can be found. Many hospital postings are multiple sheets of full text, circumventing the intent of the posting. After reviewing many hospital postings, it is clear a concisely written posting can easily fit on one 11” x 17”

sheet of paper. For hospitals unable to do so, postings must be larger rather than multiple sheets.

Subdivision (a)(2): Existing subdivision (a)(6) is renumbered to (a)(2) as a result of the amendments above. Existing text is worded so hospitals must have the posting translated into the languages spoken by five percent or more of the limited English proficient population served by the hospital. This could require hospitals to have many different postings. The postings are already required to have information on how patients may access the notice in another language, so it is more economical and feasible to only require the posting to be in English and Spanish (which is the most common language spoken by the limited English proficient population in California). Language is also added to require the different languages to be on separate postings. Putting too much text in the posting clutters the information and decreases its effectiveness.

Subdivision (b): Existing subdivision (b) is amended to add the word “only,” to limit the information that can appear in the posting to the identified information. Hospitals are including too much irrelevant information in the posting, like information on when notices about financial assistance will be provided. This is currently not out of compliance, but the information overload defeats the purpose of the posting. Hospitals have asked for guidance on what should be included in the posting, so this clarification will help hospitals parse down the posting to only the relevant and necessary information. “Shall” is amended to “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (b)(1): Existing subdivision (b)(1) is amended to replace “a” with “the” because having “Help Paying Your Bill” as “a” main title means it could be one of many main titles. Requiring it to be “the” main title ensures that it is in fact the main title. Language is added to require the title to be in a font large enough to span at least half the width of the posting. This ensures the title is large enough to be noticeable, will adjust proportionally to the size of the posting, and measuring by width provides a standard that is easy to measure despite any posting size fluctuation. Postings are meant to draw attention. Requiring the posting title to be “Help Paying Your Bill” was also an effort to increase the probability that a patient would notice it mixed in with all the other notices hospitals are required to post on their walls. Without a specific font size requirement, hospitals can (and do) use postings that have the title in the same size as the body text.

The requirement that the title be followed by “information about the availability of discount payment and charity care programs” is amended to “a short statement about the availability of discount payment and charity care programs, including eligibility criteria.” “Information” is very broad and requiring a “short statement” that includes eligibility criteria helps narrow the focus and ensures the basic information about the programs is included in the notice. The unnecessary word, “programs,” is also removed to be more concise.

Subdivision (b)(2): Existing subdivision (b)(2) is amended for clarity. Existing language is worded so the posting must only include contact information for a hospital employee or office where the patient may obtain information about the discount payment and charity care policies and how to apply, but not the actual information on how to apply. The language is amended to require contact information and information on how to apply. All hospitals have an application that is available on their website. Providing this information in the posting is simpler and easier for patients to obtain the application rather than having to call and ask hospital staff where the application can be found.

Subdivision (b)(3): Existing subdivision (b)(3) is amended to be more concise. The Hospital Bill Complaint Program Notice is already outlined in existing section 96051.3 (which is renumbered to 96051.19). Rather than repeating the notice statement in its entirety every time it is mentioned, the text is reduced to the section reference to avoid repetitiveness and be more concise.

Subdivision (b)(4): Existing subdivision (b)(4) is amended to be more concise. As with the Hospital Bill Complaint Program Notice, rather than repeating the Health Consumer Alliance Notice in multiple sections, new section 96051.20 is being added to mirror the Hospital Bill Complaint Program Notice section to reduce repetitiveness and be more concise.

Subdivisions (b)(5) and (b)(6): Existing subdivision (b)(5) and (b)(6) remain unchanged.

Subdivision (c): Existing subdivision (c) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (d): Existing subdivision (d) remains unchanged.

Section 96051.16

Existing section 96051.11 is renumbered to 96051.16 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to remove unnecessary words, improve plain language, and replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (a)(1): Existing subdivision (a)(1) is amended to remove unnecessary words, improve plain language, and replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (a)(1)(A): Existing subdivision (a)(1)(A) is amended to include “for discount payment and charity care” to adjust to the removal of that language in subdivision (a)(1).

Subdivision (a)(1)(B): Existing subdivision (a)(1)(B) remains unchanged.

Subdivision (a)(1)(C): Existing subdivision (a)(1)(C) is amended to fix a grammatical error and the “(s)” is removed since a single application is being required.

Subdivision (a)(1)(D): Existing subdivision (a)(1)(D) is amended to require contact information for the office and not just the name of the office where a patient may go for more information. Although this may be implied, the amendment makes it clear.

Subdivision (a)(1)(E): New subdivision (a)(1)(E) is added and existing subdivision (a)(5) is repealed to consistently reference the Hospital Bill Complaint Program Notice in the same manner throughout the regulations, and to include the requirement in the same subdivision that lists the other website content requirements for better organization.

Subdivision (a)(2): Existing subdivision (a)(2) is amened to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (a)(2)(A): Existing subdivision (a)(2)(A) is amended to replace “Hospital” with “The” because it is already established in subdivision (a)(2) that it is the hospital’s website.

Existing section 96051.11(a)(2)(B) is repealed as it is unnecessary. A website header and footer are visible on all webpages. As a result, if the required link is in the header and footer, it will also be on any webpage where the patient may find information about paying a bill.

Subdivision (a)(2)(B): Existing subdivision (a)(2)(C) is renumbered to (a)(2)(B) as a result of the amendments above. References to the hospital are removed since it is already established in subdivision (a)(2) that it is the hospital’s website. “On the” is replaced with “in a” for more accurate phrasing related to how drop-down menus work.

Subdivision (a)(3): Existing subdivision (a)(3) is amended to remove unnecessary text. Websites are built so that all links within the header and footer are the same size. A hospital would have to manually write the hypertext markup language to make the “Help Paying Your Bill” link smaller than the other font and therefore noncompliant, which is unlikely to ever happen. As a result, the language is shortened to only apply to links other than within the header and footer and the remaining text is amended to adjust for the text removal. The “/” is changed to “and/or” for better clarity and “shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Existing section 96051.11(a)(4) is repealed. The font style and size for the “Help Paying Your Bill” link is already address in subdivision (a)(3). Requiring that the link also be “reasonably designed to be noticeable to average patients using the hospital’s website” is ambiguous and repetitive.

Section 96051.17

Existing section 96051.2 is moved and renumbered to 96051.17 for better organization and consistency. Article 3 is about the notice and posting requirements, and eligibility determination letters are a notice.

Subdivision (a): Existing subdivision (a) is amended to be clearer and more concise to improve readability.

Subdivision (a)(1): Existing subdivision (a)(1) is combined with existing subdivision (a)(2) and amended to be clearer and more concise to improve readability.

Subdivision (a)(2): New subdivision (a)(2) is added to separate existing subdivision (a)(3) into separate subdivisions and state the requirement more clearly.

Subdivision (a)(3): Existing subdivision (a)(3) is reduced to only the language about reasonable payment plan options because of the amendment in (a)(2).

Subdivision (a)(4): New subdivision (a)(4) is added to ensure hospitals include a statement about the specific information or documentation needed to determine eligibility. This is necessary because hospitals have sent eligibility determination letters stating the patient was denied because not all information or documentation was provided, but the letter does not state what specifically the patient failed to provide so the issue can be fixed. If the letter contained the information, a patient could provide it or reapply for financial assistance. Without the information, the burden is on the patient to go through the dispute process with the hospital just to find out what information or documentation was missing from their application.

Subdivision (a)(5): Existing subdivision (a)(4) is renumbered to (a)(5) as a result of the amendments above. “Name of the hospital office, contact name, and contact information,” is amended to “Contact information for the hospital office” to be more concise. “Decision” is replaced with “determination” for consistent phrasing.

Subdivision (a)(6): Existing subdivision (a)(5) is renumbered to (a)(6) as a result of the amendments above. Text is amended to match previous phrasing referencing the Hospital Bill Complaint Program Notice for consistency and the section number is updated to coincide with the renumbering.

Subdivision (a)(7): Existing subdivision (a)(6) is renumbered to (a)(7) as a result of the amendments above. Text is amended to match previous phrasing referencing the Health Consumer Alliance Notice for consistency and the section number is updated to coincide with the renumbering.

Section 96051.18

Existing section 96051.7(d) is moved and renumbered to new section 96051.18 for better organization and consistency. Notice requirements about payment plans

becoming inoperative should be in Article 3, which is about the notice and posting requirements. “Shall” is amended to “must.” (See the explanation of proposed amendments to section 96051.1(c) above). “Bill” is replaced with “payment” as it is the patient’s missed payment of the bill that triggers the action.

Section 96051.19

Existing section 96051.3 is moved and renumbered to 96051.19 for better organization and consistency. Article 3 is for notice and posting requirements, and the Hospital Bill Complaint Program Notice is a notice.

“Shall” is amended to “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Existing language requires the verbatim statement included in the regulation, so the word “substantially” is added to allow flexibility when the statement is altered but conveys the same information. There are currently two versions of the Hospital Bill Complaint Program Notice in the regulations, so the statement is amended to the Department’s preferred version which does not include the first sentence and adds “State of California’s.” With the inclusion of “substantially,” using the alternate version will not be a violation. The web address is also amended to “hcai.ca.gov/HospitalBillHelp” to make it shorter and more user-friendly with less characters to type.

Section 96051.20

New section 96051.20 is added to parallel the Hospital Bill Complaint Program Notice section. As with the Hospital Bill Complaint Program Notice, the Health Consumer Alliance Notice must be included in various hospital documents. Including the notice language in one section reduces redundancies from repeating the statement in its entirety in every section where the statement is required and reduces inconsistencies since there are different versions of the statement in the existing regulations.

Article 4

Section 96051.21

Existing section 96051.12 is renumbered to section 96051.21 as a result of the amendments above.

Title: The existing title is amended to “Contact Registration and Certification” to be more concise and remove unnecessary words.

Subdivision (a): Existing subdivision (a) is amended to mirror the phrasing of renumbered section 96051.5 about contact registration for the policy submission portal. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Language about registering with the Department’s patient complaint portal is moved to subdivision (b) for better flow and to mirror section 96051.5.

Subdivision (b): Existing subdivision (b) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). And language from existing subdivision (a) described above is moved to subdivision (b).

Subdivision (b)(1): Existing subdivision (b)(1) remains unchanged.

Subdivision (b)(2): Existing subdivision (b)(2) is amended to eliminate awkward phrasing and match the phrasing of subdivision (b). If the primary contact is registering themself, they are providing their own name.

Subdivision (b)(3): Existing subdivision (b)(3) is amended to eliminate awkward phrasing and match the phrasing of subdivision (b). If the primary contact is registering themself, they are providing their own business title.

Subdivision (b)(4): Existing subdivision (b)(4) is repealed as it is unnecessary and does not reflect the current practices and needs of the Department. All communications are sent to the hospital contact through the patient complaint portal, and administrative penalty notices are sent via certified mail to the licensee and hospital addresses on file with CDPH. An address for the hospital contact is not needed.

Existing subdivision (b)(5) is renumbered to (b)(4) as a result of the amendment above but the text remains unchanged.

Subdivision (b)(5): Existing subdivision (b)(6) is renumbered to (b)(5) as a result of the amendment above and amended to require a “direct” business phone number to mirror the amendment being made in section 96051.5.

Subdivision (c): Existing subdivision (c) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Unnecessary words are also removed for simplification.

Subdivision (d): Existing subdivision (d) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). The words “if any” are added to clarify that additional users are not required, and the unnecessary word, “online,” is removed.

Subdivision (e): Existing subdivision (e) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Unnecessary words and references are also removed for simplification. It is already established that the Hospital Fair Pricing Act applies only to hospitals “licensed under Health and Safety Code section 1250(a), (b), or (f),” So this does not need to be restated.

Subdivision (f): Existing subdivision (f) is amended to replace “shall” with “must” (see the explanation of proposed amendments to section 96051.1(c) above) and remove “online” as it is unnecessary and repetitive. The certification requirement is amended to reference Code of Civil Procedure section 2015.5 to ensure compliance with the law

and eliminate the need to explicitly state what the certification must include. This mirrors the amendment being made in section 96051.7.

Notes: The reference citations in the note section are amended to add code of Civil Procedure sections 2012-2015.5 due to the amendment in subdivision (f).

Section 96051.13

Existing section 96051.13 is repealed. “Patient complaint portal” is now a defined term in section 96051, and information that a patient or authorized representative may file a complaint through the patient complaint portal is better covered in renumbered section 96051.24 about filing patient complaints. Existing language about how to file a complaint by mail is separate from the patient complaint portal and is better covered in renumbered section 96051.24 about filing patient complaints.

Section 96051.22

Existing section 96051.14 is renumbered to section 96051.22 as a result of the amendments above.

Subdivisions (a) and (a)(1): Existing subdivisions (a) and (a)(1) remain unchanged.

Subdivision (a)(2): Existing subdivision (a)(2) is amended to remove the second sentence. The information is already stated in subdivision (c)(8)(A) and is repetitive.

Subdivision (a)(3): Existing subdivision (a)(3) is amended to remove “conservator” with other grammatical changes for that removal. Under Probate Code section 1982, conservatorship only applies to adults in California and is not applicable to minors.

Subdivision (b): Existing subdivision (b) is amended to remove “conservator” with other grammatical changes for that removal. Under Probate Code section 1982, conservatorship only applies to adults in California and is not applicable to minors.

Subdivision (c): Existing subdivision (c) is amended to include language that a specific form is not required to request an authorized representative, but an optional form is available for download on the Department’s website. This is necessary to make clear that any written request can be made, but for convenience and ease, an optional form is available that requests the information required by the regulations. “Shall” is replaced with “must” (see the explanation of proposed amendments to section 96051.1(c) above) and the introductory transition language is amended to remove reference to the repealed section 96051.13.

Subdivisions (c)(1) to (c)(3): Existing subdivisions (c)(1) to (c)(3) remain unchanged.

Subdivision (c)(4): Existing subdivision (c)(4) is amended to replace “Street address, city, state, and ZIP Code” with “Mailing address” to mirror address phrasing used in other sections for consistency.

Subdivision (c)(5): Existing subdivision (c)(5) is amended to replace “Telephone” with “Phone” for consistency; all other sections use “phone.”

Subdivisions (c)(6) and (c)(7): Existing subdivisions (c)(6) and (c)(7) remain unchanged.

Subdivision (c)(8): Existing subdivision (c)(8) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (c)(8)(A): Existing subdivision (c)(8)(A) remains unchanged.

Subdivision (c)(8)(B): Existing subdivision (c)(8)(B) is amended to fix awkward phrasing.

Subdivision (d): Existing subdivision (d) is amended to replace “shall” with “will.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivisions (d)(1) to (d)(4): Existing subdivisions (d)(1) to (d)(4) remain unchanged.

Section 96051.23

Existing section 96051.15 is renumbered to section 96051.23 as a result of the amendments above. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Section 96051.24

Existing section 96051.16 is renumbered to section 96051.24 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to add clarifying information on how to submit a complaint that was in repealed section 96051.13. The text is also amended to remove unnecessary information that is already clear in statute or already stated in the regulations elsewhere. The last sentence of existing text is also removed and addressed in added text to subdivision (b).

Subdivision (b): Existing subdivision (b) is amended to include language that a specific form is not required to submit a complaint, but an optional form is available for download on the Department’s website. This is necessary to make clear that any written complaint can be made, but for convenience and ease, an optional form is available that requests the information required by the regulations. “Shall” is replaced with “must” (see the explanation of proposed amendments to section 96051.1(c) above), redundant language is removed, and language is added to make clearer that all requested information is about the patient to avoid authorized representatives from providing their own information.

Subdivision (b)(1): Existing subdivision (b)(1) is amended to reorder the words for better flow.

Subdivision (b)(2): Existing subdivision (b)(2) is amended to replace “filing for” with “patient is” for more consistent phrasing. “Conservator” is also removed with other grammatical changes for that removal. Under Probate Code section 1982, conservatorship only applies to adults in California and is not applicable to minors.

Subdivisions (b)(3) and (b)(4): Existing subdivisions (b)(3) and (b)(4) remain unchanged.

Subdivision (b)(5) to (b)(8): Existing subdivision (b)(5) is moved and renumbered to (b)(9) so the order of information requested is less disjointed and matches the order the information is presented in the optional form. As a result, existing subdivisions (b)(6) to (b)(9) are renumbered to (b)(5) to (b)(8), respectively.

Subdivision (b)(9): Existing subdivision (b)(5) is moved and renumbered to (b)(9) as described above. “Pursuant to” is replaced with “as defined by” for plain language purposes, and language is added to clarify that it is family size at the time the patient was first billed. The patient’s family income documentation, family size, and eligibility is tied to the time the patient was first billed. Clarification is needed to ensure a patient does not provide their current family size, which may now include more or less family members and would result in an incorrect eligibility determination.

Subdivision (b)(10): New subdivision (b)(10) is added to request the full names, ages, and the patient’s relationship to each family member identified. This is necessary to ensure the family members being included are in fact limited to those who qualify under the definition of the patient’s family as defined in Health and Safety Code section 127400(h), and the family size count can be adjusted by the Department accordingly as needed.

Subdivisions (b)(11) to (b)(14): Existing subdivisions (b)(10) to (b)(13) are renumbered to (b)(11) to (b)(14), respectively, as a result of the amendment above. Existing text remains unchanged.

Subdivision (b)(15): Existing subdivision (b)(14) is renumbered to (b)(15) as a result of the amendment above. The words “and paid” are removed along with associated grammatical changes. Whether a claim is paid by a third-party payor does not impact eligibility and is not relevant.

Subdivision (b)(16): Existing subdivision (b)(15) is repealed as unnecessary. Whether a patient filed a health plan grievance for a denied claim has no impact on whether the patient is eligible for financial assistance. The Department does not need to know this information and it has no impact on the Department’s ability to conduct and complete a patient complaint investigation.

Existing subdivision (b)(16) is also repealed as unnecessary. While knowing whether a patient’s injury resulted from an injury caused by a third party, including, but not limited to, car accident, work injury, or crime, may be relevant to determining whether the patient is “self-pay” or a “high medical cost patient,” the date of the injury is not relevant.

Existing subdivision (b)(17) is renumbered to (b)(16) as a result of the amendments above. “Program” is an unnecessary word and moved for simplicity.

Subdivisions (b)(17) to (b)(21): Existing subdivisions (b)(18) to (b)(22) are renumbered to (b)(17) to (b)(21), respectively, as a result of the amendments above. Text remains unchanged.

Subdivision (b)(22): New subdivision (b)(22) is added to require a short description of what the complaint is about. A patient can file a complaint about a hospital’s eligibility determination, about a hospital’s failure to provide notice about the financial assistance programs, or a number of various topics. The Department needs to know how the patient believes the hospital violated the Hospital Fair Pricing Act so it knows what specific issues to investigate, and whether the issue is within the Department’s jurisdiction so the investigation can be completed effectively and efficiently.

Subdivisions (b)(23) to (b)(25): Existing subdivisions (b)(23) to (b)(25) are amended to update the internal section references to the renumbered section numbers.

Subdivision (b)(26): New subdivision (b)(26) adds a signed acknowledgment that the Department may forward complaints to CDPH. Under Health and Safety Code section 127401(a), “The State Department of Public Health shall be responsible for the enforcement of the provisions of this article for violations occurring prior to January 1, 2024. The Department of Health Care Access and Information shall be responsible for the enforcement of the provisions of this article for violations occurring on or after January 1, 2024.” If a complaint is filed with the Department that should have been filed with CDPH, this puts the patient on notice that the complaint will be forwarded accordingly.

Subdivision (b)(27): Existing subdivision (b)(26) is renumbered to (b)(27) as a result of the amendment above. Text remains unchanged.

Subdivision (c): New subdivision (c) is added to clarify that except for authorized representatives, a complaint cannot be filed on someone else’s behalf. Because of the privacy issues involved with complaints related to a person’s medical and financial information, Hospitals cannot release just anyone’s information to the Department and the Department’s findings can only be shared with the patient.

Subdivision (d): New subdivision (d) is added to clarify that original documents should not be submitted to the Department for complaints because the documents will not be returned. This is necessary to clarify expectations about what will happen to documents submitted to the Department.

Notes: The reference citations in the note section are amended to add Health and Safety Code section 127401 to address subdivision (b)(25).

Section 96051.25

Existing section 96051.17 is renumbered to section 96051.25 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to simplify language and remove unnecessary information for better readability.

Subdivision (b): Existing subdivision (b) is amended to reflect the current process and clarify that the Department may request additional information from the patient. Many of the complaints the Department receives do not contain all the required information from existing section 96051.16 (renumbered to 96051.24). This information is necessary to determine whether the complaint is within the Department's jurisdiction and what the complaint is about. This information also needs to be obtained before sending the complaint to the hospital, otherwise the hospital will not know how to respond to it. This is necessary so patients are aware of the process and are put on notice that additional information may be requested.

Subdivision (b)(1): New subdivision (b)(1) is added to reflect the current process and clarify what happens when an incomplete complaint is received from a patient. When there is not enough information for the Department to determine jurisdiction or decipher what the complaint is about, or if additional information is needed, the Department will request the missing information and give the patient 30 calendar days to respond. Thirty days is used since it is the same amount of time given to the hospital to respond to the Department. Language is added to clarify that the patient complaint will be closed if the requested information is not received within 30 calendar days, but the Department will reopen the complaint if the information is eventually provided. This is necessary so patients are aware of the process. The Department needs to be able to close complaints where a patient is not responsive, so they are not left open indefinitely for tracking and recording purposes.

Subdivision (b)(2): Existing subdivision (b)(1) is renumbered to (b)(2) as a result of the amendment above and amended to replace "shall" with "must." (See the explanation of proposed amendments to section 96051.1(c) above). Unnecessary reference to the section on extension requests is removed for simplicity, introductory language is added to align with the amendments made in subdivision (b), and "complaint" is replaced with "Department" to use consistent phrasing.

Subdivision (b)(2)(i): New subdivision (b)(2)(i) is added to clarify what happens when a hospital response is not complete. A hospital's response may be incomplete because a wrong document was provided, or not all the questions were answered. Providing something that was previously requested should not be subject to a new response deadline because this adds further delays to the process and would allow hospitals to extend deadlines (and possibly avoid late penalties) by providing incomplete responses.

Subdivision (c): Existing subdivision (c) is amended to correct a grammatical error and replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (c)(1): Existing subdivision (c)(1) is amended to remove unnecessary words to be more concise.

Subdivision (c)(2): Existing subdivision (c)(2) remains unchanged.

Subdivision (d): Existing subdivision (d) is amended to remove “the patient and” to reflect the current process. The Department will only request additional information from the patient when the complaint is first received as described in subdivision (b)(1), so this subdivision only needs to apply to hospitals.

Subdivision (d)(1): Existing subdivision (d)(1) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Thirty calendar days is also reduced to 14 calendar days. The hospital already gets 30 calendar days to initially respond to the patient complaint. Any additional information the Department requests after that response is received is for clarifying questions or to request copies of documents that may have been mentioned and not provided but exist and are readily available to provide to the Department. Waiting 30 calendar days for these clarifications unreasonably delays the complaint investigation process when responses to requests can easily be completed in 14 days, and in the event a hospital is unable to provide a response in 14 days, an extension can be requested. Based on the Department’s current experience, hospitals already respond within 14 calendar days almost 30 percent of the time when a patient complaint has required additional information from the hospital after the hospital’s initial response. Unnecessary language referencing the extension period section is removed to be more concise.

Subdivision (d)(2): New subdivision (d)(2) is added to clarify what happens when a hospital response is not complete. A hospital’s response may be incomplete because a wrong document was provided, or not all the questions were answered. Proving something that was previously requested should not be subject to a new deadline to respond because this adds further delays to the process and would allow hospitals to extend deadlines (and possibly avoid late penalties) by providing incomplete responses.

Subdivision (e): Existing subdivision (e) is amended to replace “Upon receipt” to “After review of” for more precise language that reflects the Department’s current process. The unnecessary “and” is removed to be more concise and language stating the Department will “make a compliance determination based on the criteria outlined in the Act and this chapter” is removed as it states the obvious and is unnecessary. A compliance determination can only be made by evaluating compliance with the rules and regulations. The text is amended to more usefully state that the Department will notify the hospital of its compliance determination, so the hospital knows what to expect throughout the process.

Subdivision (e)(1): Existing subdivision (f) is moved and renumbered to (e)(1) for better organization of the information. What happens when violations are found is a subpart of the Department's compliance determination. The text is amended to improve plain language and readability, and update to the terminology currently used by the Department (i.e., "initial compliance determination" as opposed to "preliminary out of compliance notice").

Subdivision (e)(2): Existing subdivision (e)(1) is renumbered to (e)(2) as a result of the amendment above. "Shall" is replaced with "will" (see the explanation of proposed amendments to section 96051.1(c) above), the terminology referenced in subdivision (e)(1) is updated here as well, and clarifying language is added that the hospital must also take corrective action, if required.

Subdivision (e)(3): Existing subdivision (e)(2) is renumbered to (e)(3) as a result of the amendment above. The text is amended to improve plain language and readability, and update to the terminology currently used by the Department.

Subdivision (f): Existing subdivision (g) is renumbered to (f) as a result of the amendment above. Existing subdivision (g) outlines the hospital's required actions if the hospital does not file an appeal, and existing subdivision (h) outlines the hospital's required actions if the hospital does file an appeal. However, the actions are the same and the only difference is when the deadline starts. To eliminate repetitiveness, the two subdivisions are combined into the renumbered subdivision (f). "Final determination notice" is updated to "final compliance determination and administrative penalty notice" to reflect the terminology currently used by the Department, and "shall" is replaced with "must." (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (f)(1): Existing subdivision (g)(1) is repealed to eliminate conflicting and confusing deadlines. Health and Safety Code section 127440 already requires hospitals to refund patients within 30 days after determining a patient overpaid. If a hospital determined a patient is eligible for financial assistance and is owed a refund after receiving a patient complaint (or earlier on its own), then the 30-day deadline begins when that determination is made. The existing text creates another 30-day deadline that begins the day the Department's final determination notice is sent at the closure of the complaint investigation, which could be, and likely will be, after the hospital's determination was made. This language would extend the deadline when the refund needs to be made and conflict with the law.

Existing subdivision (g)(2) is renumbered to (f)(1) as a result of the amendments above. The text is amended to clarify that the proof of reimbursement must include proof of interest paid. The text about the deadline is removed because it is already stated in subdivision (f) and does not need to be repeated.

Subdivision (f)(2): Existing subdivision (g)(3) is renumbered to (f)(2) as a result of the amendments above. The text about the deadline is removed because it is already stated in subdivision (f) and does not need to be repeated.

Section 96051.26

Existing section 96051.18 is renumbered to section 96051.26 as a result of the amendments above.

Title: The existing title is amended to “Extension Requests” to mirror section 96051.9 for the policy review process for consistency.

Subdivision (a): Existing subdivision (a) is amended to replace “a reasonable extension of time” with 14 calendar days. As discussed previously, the extension request process will now be automated, so a set amount of time is needed. Based on current experience reviewing patient complaints, the Department has determined an additional 14 days is a sufficient and reasonable amount of time for the hospital to respond. For the complaints that have been sent to hospitals since the Hospital Bill Complaint Program’s inception, hospitals have been able to respond within 30 days almost 50 percent of the time, and 82 percent of the responses are submitted within 45 days. Language requiring hospitals to “describe the actions being taken to obtain the information or records and when receipt is expected” is being removed because the extension request process will now be automated and this is no longer applicable. Reviewing and responding to extension requests is time consuming and automating the process will eliminate that burden.

Subdivision (b): Existing subdivision (b) is repealed in its entirety. Since the extension requests will be fully automated with the limited number of extensions automatically granted, the reasons for the extension requests no longer need to be considered. Removing this text is necessary to align with the process being used.

Existing subdivision (c) is renumbered to (b) as a result of the amendments above and amended to be more concise.

Section 96051.19

Existing section 96051.19 is repealed. When the existing regulations were first proposed, the originally proposed text required that debt collection cease while a complaint was pending. The language was amended during the comment period to the existing text, but existing text is now duplicative of the statutory requirements in Health and Safety Code section 127425 and does not need to be stated in the regulations.

Article 5

Section 96051.20

Existing section 96051.20 is repealed. Subdivision (a) is duplicative of the authority outlined in Health and Safety Code section 127401 and does not need to be repeated. The compliance history language being referenced in existing section 96051.26 is being removed, so subdivision (b) is no longer applicable or necessary.

Section 96051.27

Existing section 96051.21 is renumbered to section 96051.27 as a result of the amendments above.

Title: The existing title is amended to “Late Penalties” to eliminate unnecessary words and be more concise.

Subdivision (a): Existing subdivision (a) is amended to improve plain language, update terms to those in the amended definitions for clarity and consistency, and update the internal section references. The internal reference sections are expanded to include those in existing subdivision (b), which is repealed to avoid repetitiveness. Existing text states that there is a daily penalty for each calendar day after the due date that the required document “is not filed.” This can be interpreted to mean that the day the document is filed will not incur a penalty, which was not the Department’s intent. The language is amened to more clearly and plainly state that there is a penalty for each day after the due date that the required policy submission or response is late.

Subdivision (a)(1): New subdivision (a)(1) is added to address situations where a response appears complete on its face, but it is later discovered to be incomplete due to a mistake. During the policy review process, there have been times when a hospital’s response appeared complete because all the required documents appeared to be submitted, but when the files were opened to review, a wrong document was provided. Assessing late penalties for the incomplete response would be unfair if the hospital was not aware of the mistake, and the amount of the penalties would be dependent upon the Department’s discovery, which the hospital has no control over and can vary depending on how busy the Department is with other policy reviews or patient complaint investigations. To address this fairly, the Department will notify the hospital of the issue, and the hospital will have 3 calendar days to provide a complete response before late penalties begin to accrue. Three days is a reasonable amount of time because if the hospital thought it submitted the correct document, the correct document exists and is readily available to send to the Department.

Subdivision (b): Existing section 96051.28(c) is moved and renumbered to subdivision (b) for better organization so all regulations related to late penalties appear in the same section. Existing text remains unchanged.

Subdivision (c): Existing section 96051.22(a) is moved and renumbered to section 96051.27(c) for better organization so all regulations related to late penalties appear in the same section. Existing sections 96051.22(a) and (b) are repetitive and combined into subdivision (c). The text is amended to read, “The Department will notify the hospital’s designated contact of an accrued late penalty,” for better readability, simplicity, and clarity.

Subdivision (d): New subdivision (d) is added to clarify that late penalties will be added to the administrative penalty assessment issued with the final compliance determination. During a policy review or complaint investigation, there could be multiple

late penalties assessed if the hospital provides multiple late responses. To avoid multiple appeals related to the same review or investigation, late penalties will be added to the final compliance determination and administrative penalty notice so they fall under the same appeal.

Notes: The reference citations in the note section are amended to add Health and Safety Code sections 127436 and 127440 to account for the subdivisions that were moved to this section.

Section 96051.22

Existing section 96051.22 is repealed. Subdivisions (a) and (b) are moved to section 96051.21 as described above. Subdivision (c) is repealed since it is unnecessary with existing sections 96051.21 and 96051.22 being combined into one section.

Section 96051.28

Existing section 96051.23 is renumbered to section 96051.28 as a result of the amendments above.

Title: The existing section title is amended to “Violation Classification” to better describe what the amended section is about.

Intro: Language is added to introduce the violation classifications.

Subdivision (a): Existing subdivision (a) is repealed in its entirety as the clarification it provided is no longer needed. Existing regulations have two penalty structures and two different base penalties for policy review and patient complaints. To avoid confusion and simply the process the regulations are amended to one penalty structure.

Existing subdivision (b) is repealed since it is addressed by the new introductory language other new sections.

Subdivision (a): Existing subdivision (b)(1) is renumbered to (a) as a result of the amendments above. The text is amended to use plain language to improve readability and clarity. Information about the penalty amount is moved to section 96051.29.

Subdivision (b): Existing subdivision (b)(2) is renumbered to (b) as a result of the amendments above. The text is amended to use plain language to improve readability and clarity. Information about the penalty amount is moved to section 96051.29.

Subdivision (c): Existing subdivision (b)(3) is renumbered to (c) as a result of the amendments above. The text is amended to make it clearer that the Minor classification is anything that is not Major or Moderate. Simplifying the definition improves readability and clarity. Information about the penalty amount is moved to section 96051.29.

Existing subdivision (b)(4) is repealed since the issue is covered in section 96051.32.

Existing subdivision (c) is repealed since the two penalty structures are being combined.

Subdivision (d): New subdivision (d) is added to add a distinct classification for repeat violations. Repeat violations have higher penalty adjustments, so the violation needs to be classified as “Repeat” for compliance history tracking, so it is clear what adjustments apply.

Subdivision (e): New subdivision (e) is added to make “willful” a penalty classification. Adjustments for willful violations are discussed in existing section 96051.26, but a separate classification is clearer since “willfulness” in itself is a type of violation. The definition is an amendment of existing section 96051.26(a)(3)(A) but in plain language for clarity.

Section 96051.24

Existing section 96051.24 is repealed. Existing subdivision (a) misstates the law and is removed to avoid confusion. The clarification is correctly and more plainly stated in the new section 96051.29(b). Existing subdivision (b) is removed because it does not reflect the Department’s current process. The regulations were originally drafted before the processes and systems were in place for patient complaints. The Department originally intended for patients to submit a separate complaint for each date of service or admission. However, over a year of experience in patient complaint investigations revealed it is unnecessarily burdensome for patients, the Department, and the hospital to require multiple complaints that can easily be consolidated into one investigation. This definition needs to be removed so the regulation conforms to the most efficient and least burdensome practices. Existing subdivision (c) is unnecessary as only the submitting patient’s circumstances are investigated when a complaint is submitted.

Section 96051.25

Existing section 96051.25 is repealed. The penalty structure of policy review and patient complaints is now combined to avoid the confusion of having two different base penalty amounts depending on whether a penalty is for policy review versus a patient complaint, and this separate section is not necessary. The penalty structure for policy review was chosen because hospitals are already familiar with those penalties and penalties for patient complaints have not yet been assessed. The single penalty structure for complaints also creates unfairness. Since the base penalty for the single penalty is only based on one of two amounts depending on whether there was financial harm and does not consider the number of violations, this means a complaint with 50 violations could be assessed the same penalty amount as a complaint with one violation. Shifting the complaint penalties to the penalty structure used for policy review will better account for these issues to ensure hospitals are penalized appropriately. Having clearer penalty regulations also makes it easier for hospitals to know what to expect and better avoid the penalties. Existing subdivision (b) is moved and amended to section 96051(e).

Section 96051.29

New section 96051.29 is added to address the base penalties that will be used for both policy review and patient complaint investigations.

Subdivision (a): New subdivision (a) is added to list the base penalty amounts that will be used for both policy review and patient complaints for each violation. The amounts listed are what are used in existing section 96051.23 for policy reviews. (See explanation for repeal of section 96051.25 above).

Subdivision (b): New subdivision (b) is added to address the single violation issue raised in Health and Safety Code section 127436(a) (i.e., "multiple violations identified during the same investigation shall constitute a single violation for purposes of assessing an administrative penalty"). The statute does not mean that all violations arising out of a complaint investigation are subject to one penalty (as stated in existing section 96051.24(a), which is to be repealed). It means multiple instances of the same violation identified in the same investigation will be considered one violation. For example, if a patient received three billing statements from a hospital and all three bills did not have the Hospital Bill Complaint Program notice, instead of being counted as three separate violations, those multiple violations would constitute a single violation for failure to include the required statement. Clarifying language is also added to explain that this does not limit an assessment of multiple penalties for multiple different violations in the same investigation. This is necessary to explain how penalties will be assessed.

Section 96051.30

Existing section 96051.26 is renumbered to 96051.30 as a result of the amendments above.

Title: The existing title is amended to be more concise.

Subdivision (a): New subdivision (a) is added to clarify that this section only applies to patient complaint investigations. With the existing separate penalty structures for policy review and patient complaints, it was indicated elsewhere that this section only applies to patient complaints, but that language is removed and now needs to be stated here instead. Although the base penalties will be the same, there will still be different types of penalty adjustments for policy review and patient complaints.

Subdivision (b): Existing subdivision (a) is renumbered to (b) as a result of the amendment above. Text is amended to make it clearer that the base penalty for each violation will be adjusted according to the factors described to calculate the adjusted penalty.

Subdivision (b)(1): Existing subdivision (a)(1) is repealed. Health and Safety Code section 127436(b)(4)(B) requires the Department to consider "The nature, scope, and severity of the violation, including whether the hospital's policies, postings, and

screening practices are in compliance with Sections 127405 to 127435, inclusive, or whether the violation was a mistake that resulted in a violation of those policies and practices." Instead of making this specific in the regulations, existing subdivision (a)(1) just restates part of the law, and then only adjusts the penalty depending on whether the hospital's policies, postings, or screening practices are in compliance. Amendment is necessary to address, make specific, and clarify each factor individually.[4]

New subdivision (b)(1) and related subdivisions, (b)(1)(A) and (b)(1)(B), describe how the severity of actual and potential financial harm to patients is factored into determining the adjusted penalty for each violation. This is necessary because the severity of the violation in a particular case may vary, with some violations being more egregious than others, warranting a greater penalty.

Subdivision (b)(1)(A): New subdivision (b)(1)(A) states that the degree of severity is based on actual or potential financial harm. The severity of a violation refers to the degree of seriousness with which the violation is viewed and using actual or potential financial harm creates a measurable standard.

Subdivision (b)(1)(B): New subdivision (b)(1)(B) sets severity levels in (b)(1)(B)(i) through (b)(1)(B)(iii), as "High," "Medium," or "Low," respectively, and describes the associated penalty adjustment, if any. The severity levels reflect the legislative intent of Health and Safety Code section 127435(b)(4) that violations of requirements take on greater or lesser significance depending upon the severity and actual or potential financial harm that did or could occur, in the judgement of the Department, as a result of the hospital's actions. The severity levels provide a tool to determine the seriousness of identified violations and guide assessment of administrative penalties. The percentages for upward adjustment of the penalty are scaled to correspond to the degree of financial harm to the patient. The "High" level reflects the most serious consequence for noncompliance with the requirements where the violation results in actual financial harm to the patient. Existing subdivision (a)(1) (repealed above) uses a 20 percent increase for "nature, scope, and severity," so this will become the highest level and 20 percent of the base penalty will be added for High severity. The "Medium" level is for violations where there is no actual financial harm, but there is potential for financial harm. The Medium level acknowledges that potential financial harm to patients exists but has not yet been realized. For Medium severity, 10 percent of the base penalty is added. Ten percent is used since it is in the middle of zero and 20 percent. The "Low" level is for violations with no actual and no potential financial harm. No adjustment is applied for Low severity violations because the base penalty is sufficient.

Subdivision (b)(2): New subdivision (b)(2) and related subdivisions (b)(2)(A) and (b)(2)(B), discuss the scope or extent of noncompliance and are necessary to make

[4] The nature of the violation refers to the fundamental character of the violation. This factor is already addressed by the base penalty classifications, which are classified according to the nature of the violation.

clear how the Department measures scope of noncompliance when determining the adjusted penalty for each violation.

Subdivision (b)(2)(A): New subdivision (b)(2)(A) states that scope is based on the number of patients actually or potentially impacted, depending on whether it is an isolated incident or a widespread issue. Scope refers to the extent or range covered by a violation and measuring by the number of patients actually or potentially impacted creates a measurable standard.

Subdivision (b)(2)(B): New subdivision (b)(2)(B) defines the levels of "scope of noncompliance" as "High," "Medium," and "Low," in related subdivisions (b)(2)(B)(i) through (b)(2)(B)(iii), respectively. This language is necessary to make clear how scope is measured. The percentages for upward adjustment of the penalty are scaled to correspond to the number of patients actually or potentially impacted. If the violation is a widespread issue due to noncompliant hospital policies, websites, or postings, scope is based on the number of potentially impacted patients according to the hospital's licensed bed count. A hospital's bed count provides a benchmark for the number of patients that could potentially be impacted by systemic issues. The licensed bed count also provides a consistent value to measure scope as opposed to actual patient admissions which are in constant fluctuation. Existing subdivision (a)(1) (repealed above) uses a 20 percent increase for "nature, scope, and severity," so this will become the penalty ceiling by adding 20 percent of the base penalty for the "High" level, which is defined as a widespread issue due to noncompliant hospital policies, websites, or postings, for hospitals with over 250 licensed beds. As it is in the middle, ten percent is used for the "Medium" level, which is defined as a widespread issue due to noncompliant hospital policies, websites, or postings, for hospitals with 51 to 250 licensed beds. Mirroring the severity levels, there is no adjustment for the "Low" level, which is defined as an isolated incident impacting one patient, or a widespread issue due to noncompliant hospital policies, websites, or postings, for hospitals with up to 50 licensed beds. Based on current licensing data, hospital licensed bed counts range from 4 to 919 beds, with 150 being the average. The levels were chosen to account for that range with such extreme highs and lows, so that most of the hospitals would fall in the middle. With the Medium level at 51 to 250 patients (based on beds), 49 percent of the hospitals fall in this level. With the Low level at up to 50 patients, this accounts for 29 percent of hospitals and prevents a large number of the smaller hospitals from receiving the enhanced penalty. That leaves 22 percent of the hospitals subject to the High level for over 250 patients.

Subdivision (b)(3): Existing subdivision (a)(2) is repealed in its entirety. The existing introductory language of (a)(2) is unnecessary. The regulations are only about the Hospital Fair Pricing Act, so compliance history is only going to be about compliance with the Hospital Fair Pricing Act. The existing regulations did not go into effect until January 1, 2024, so it does not need to be stated that violations of this chapter prior to January 1, 2024, will not be considered; they do not exist. It also does not need to be stated that violations of the Hospital Fair Pricing Act prior to January 1, 2022, will not be considered. The CDPH State Enforcement Actions Dashboard which shows all state

enforcement actions CDPH has issued since July 1, 1998, shows zero enforcement actions for violations of the Hospital Fair Pricing Act. Existing text about compliance history primarily addresses penalty increases due to repeat violations. This is addressed by the new “Repeat” violation classification.

New subdivision (b)(3) and related subdivisions (b)(3)(A) and (b)(3)(B) are added to address compliance history as required by Health and Safety Code section 127435(b)(4)(C), to replace the repealed subdivision (a)(2) mentioned above.

Subdivision (b)(3)(A): New subdivision (b)(3)(A) includes a more generalized statement of what compliance history is than what was discussed in repealed subdivision (a)(2) above.

Subdivision (b)(3)(B): New subdivision (b)(3)(B) defines the levels of compliance history as “Good,” “Fair,” and “Poor,” in related subdivisions (b)(3)(B)(i) through (b)(3)(B)(iii), respectively. Existing subdivision (a)(2)(A) (repealed above) provides a 5 percent reduction to the base penalty if a hospital has zero violations within the last 3 years. To increase incentive, subdivision (b)(3)(B)(i) states that for a “Good” compliance level, 10 percent of the base penalty will be subtracted if within the last three years, no Major, Repeat, or Willful violations and less than five Moderate or Minor violations have been assessed. This provision provides a penalty reduction to hospitals that have consistently avoided Major, Repeat, and Willful violations, and have had a very limited number of Moderate or Minor penalties assessed during the 3-year lookback period provided by repealed subdivision (a)(2). Fair compliance history also provides a penalty reduction to hospitals that have consistently avoided Major, Repeat, and Willful violations, but only 5 percent of the base penalty will be subtracted if the hospital has had 6 to 20 Moderate or Minor violations assessed. No adjustments will be provided for a “Poor” compliance history which includes a Major, Repeat, or Willful violation or more than 20 Moderate or Minor violations within the last 3 years.

Subdivision (b)(4): New subdivision (b)(4) and related subdivision (b)(4)(A), are added to address penalty adjustments for Repeat violations.

Subdivision (b)(4)(A): Existing subdivision (a)(2)(C) (repealed above), partially addressed repeat violations in compliance history but only to the extent of the first repeated violation. Repeated violations of the same standards are important in evaluating a hospital’s compliance history because they indicate that the facility has been unable or unwilling to correct a violation, that previous penalties were not high enough to deter the hospital from violating again, and that a higher penalty is warranted. To better address this situation and add a greater deterrent, subdivisions (b)(4)(A)(i) through (b)(4)(A)(iii) set a progressively increasing multiplier that is applied to the base penalty after the first, second, and subsequent repeated occurrences of the same violation. Existing subdivision (a)(2)(C), which is being repealed, increased the base penalty by 50 percent for the first repeat. This is replaced by the 1.5 multiplier which is an equivalent increase. For the second repeat, two times the base penalty will be added, and for the third repeat and beyond, three times the base penalty will be added.

The progressive increases were kept minimal given that larger increases would be rendered useless by the statutory maximum penalty for patient complaints. Multipliers are used instead of percentage increases because they are easier to understand than stating 50 percent, 100 percent, or 300 percent of the base penalty will be added.

Subdivision (b)(5): Existing subdivision (a)(3) is repealed in its entirety. Existing subdivision (a)(3) is renumbered and amended to (b)(5) as a result of the amendments above. Existing subdivision (a)(3)(A) is unnecessary since Willful violations are being added as a defined classification.

New subdivision (b)(5) and related subdivision (b)(5)(A) sets the base penalty adjustment for Willful violations. Existing regulations provide a 20 percent increase for a willful violation, but an intentional violation should have more severe consequence than the other penalty adjustments for a deterrent and a punishment for the intentional act. Subdivision (b)(5)(A) provides that 3 times the base penalty will be added for violations classified as Willful.

Exiting subdivision (a)(4) is repealed and addressed in the newly added section 96051.31.

Existing subdivision (a)(5) is repealed in its entirety. Penalty adjustments for corrective actions are addressed in the newly added section 96051.32.

Section 96051.31

New section 96051.31 is added to address penalty adjustments in the “interest of fairness.” Under AB 2297, Health and Safety Code section 127436(a) was amended to authorize the Department to waive or reduce an administrative penalty in the interest of fairness.

Subdivision (a): New subdivision (a) states that this section will apply to all penalty assessments. This is necessary so hospitals are aware that these penalty waivers and reductions are available for both policy reviews and patient complaints.

Subdivision (b): New subdivision (b) states that the Department may waive or reduce a penalty in the interest of fairness on a case-by-case basis. “Case-by-case” is used as opposed to a rigidly defined standard since fairness is dependent upon the facts of each individual circumstance. However, subdivisions (b)(1) through (b)(3) outline examples of situations where interest of fairness applies. These are circumstances the Department has noted during the 2024 biennial policy review, but other circumstances may require consideration of additional relevant factors which are necessary to determine a lesser but appropriate penalty amount.

Subdivision (b)(1): Existing section 96051.26(a)(4) is now addressed in (b)(1). Health and Safety Code section 127436(b)(4)(D) requires the Department to consider “Factors beyond the facility’s control that restrict the facility’s ability to comply with this chapter or the rules and regulations promulgated thereunder.” With the creation of the “interest of

fairness" reductions, this factor fits better in this section for organizational purposes since it relates to fairness as it would be unfair to hold a hospital accountable for factors beyond its control.

Subdivision (b)(2): New subdivision (b)(2) is added to address situations where a mistake resulted in a violation of the hospital's policies and practices, as required by Health and Safety Code section 127436(b)(4)(B). For example, if a hospital determined a patient is ineligible for financial assistance because of a math error when determining federal poverty level, but later amends the eligibility determination when the error is discovered, the penalty would be waived or reduced in the interest of fairness.

Subdivision (b)(3): New subdivision (b)(3) is added to address situations where the purpose of a statutory or regulatory requirement becomes useless because of the greater benefit offered by the hospital's policies. Interest of fairness will be considered to avoid penalizing hospitals that are providing greater benefits than what the Hospital Fair Pricing Act requires. For example, Health and Safety Code section 127405(c) requires hospital discount payment policies to include payment plan options with specific terms. However, if a hospital provides 100 percent free care to all financially qualified patients, then there is no need for a payment plan. The Department cannot waive statutory requirements, so if a generous policy did not include language about payment plans, it would be a violation, but interest of fairness could be used to waive the penalty.

Section 96051.32

Existing section 96051.31 is renumbered to 96051.32 as a result of the amendments above.

Subdivision (a): Existing section 96051.31 does not have subdivisions, but with additional text being added to the section, the existing text is renumbered as subdivision (a). Text remains unchanged.

Subdivision (b): New subdivision (b) is added to introduce how penalties will be waived or reduced when a hospital takes corrective action, with the caveat that no waiver or reduction will be given when there is actual financial harm, or for Repeat or Willful violations. Actual financial harm is the most severe consequence of a hospital violation and Repeat and Willful violations require an overt act to intentionally violate the law or make no efforts to prevent the violation from recurring. These are not situations where a hospital should get the benefit of a penalty waiver or reduction.

Subdivision (b)(1): New subdivision (b)(1) addresses how penalties will be waived or reduced when a hospital takes corrective action in response to a Department request. Subdivision (b)(1)(A) was previously addressed in existing sections 96051.23(b)(4) and 96051.25(a)(3) stating, "There is no penalty for alleged violation(s) that do not affect patient access to, or eligibility for, the hospital's discount payment or charity care programs, provided the hospital takes corrective action as directed by the Department." This is moved to subdivision (b)(1)(A) and stated in more concise plain language as,

“Penalty will be waived for Minor violations.” Hospitals should have an incentive to correct violations, so subdivision (b)(1)(B) adds that 50 percent of the base penalty for Moderate and Major violations will be subtracted.

Subdivision (b)(2): New subdivision (b)(1) addresses how penalties will be waived or reduced when a hospital proactively takes corrective action before the Department requests it. Existing section 96051.26(a)(5) partially addresses this, but the standard is being moved here and amended for simplicity to match subdivision (b)(1). To promote the practice of hospitals being proactive in recognizing and correcting violations on their own, greater reductions are warranted and provided in this subdivision.

Section 96051.33

Existing section 96051.27 is renumbered to 96051.33 as a result of the amendments above.

Subdivision (a): New subdivision (a) is added to clarify how the final penalty is determined for policy reviews. Existing language only addresses the final penalty for complaint investigations and there is a distinction since complaint investigations are subject to a statutory maximum penalty.

Subdivision (b): Existing text in this section did not contain subdivisions and is moved and renumbered to subdivision (b) as a result of the amendment above. The text is amended to improve readability, use plain language, and remove the internal section references that are no longer applicable. Clarifying language is added to explain that for the purpose of penalty calculation, the cumulative total penalty may exceed the statutory maximum, so long as the final penalty does not exceed the statutory maximum.

Section 96051.28

Existing section 96051.28 is repealed. Existing subdivision (a) is duplicative of the statutory requirement of Health and Safety Code section 127440 and does not need to be restated. Existing subdivision (b) is also already covered by Health and Safety Code section 127440. As discussed previously, existing subdivision (c) is moved and renumbered to section 96051.27(b). Existing subdivision (d) is already covered by section 96051.27(c).

Section 96051.34

Existing section 96051.29 is renumbered to 96051.34 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to remove “pursuant to the Act and this chapter” because that has already been established and does not need to be restated. Existing subdivisions (a)(1) to (a)(3) are repealed and relevant language is combined and reduced to “a payment plan and/or reduction of the penalty if immediate

full payment would cause financial hardship," to eliminate repetitiveness and use plain language to improve clarity and readability.

Subdivision (b): Existing subdivision (b) is amended to replace "shall" with "must." (See the explanation of proposed amendments to section 96051.1(c) above). The text is amended to reflect the amendments in subdivision (a) and use plain language. The "or" is replaced with "and" to correct an error; Health and Safety Code section 124840 defines what qualifies for the "small and rural hospital" designation.

Existing subdivisions (b)(1) and (b)(2) are repealed. A small and rural hospital's failure to request a payment plan or penalty reduction within 10 working days after the issuance of the administrative penalty would not preclude the hospital from filing an appeal disputing the penalty amount. The extension does not extend the appeal deadline (which is 30 calendar days after the penalty assessment) and allowing an extension on the time to request a payment plan and/or penalty reduction does not leave the Department sufficient time to make a determination in time for the hospital to timely file an appeal if the request is denied. The existing amount of time without an extension already requires a fast turnaround from the Department.

Subdivision (c): Existing subdivision (c) is amended to be more concise.

Section 96051.30

Existing section 96051.30 is repealed as it is unnecessary and misstates the law. Health and Safety Code section 127436(b)(4) sets a $40,000 penalty cap for complaint investigations, and that $40,000 amount "shall be adjusted every five years to reflect the percentage change in the calendar year average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics." As the cap increases, the base penalties may need to be increased accordingly, but it does not need to be clarified that the adjustment will only be made to the base penalties. The penalty adjustments are a percentage of the base penalty, so the base penalties are the only amounts that would be adjusted.

Article 6

Section 96051.35

Existing section 96051.32 is renumbered to 96051.35 as a result of the amendments above.

Title: The existing title is amended to "Filing an Appeal," to move the sub-heading from subdivision (a) and so the article and section do not have the same title.

Subdivision (a): Existing subdivision (a) is amended to existing text and "Filing an Appeal" is moved as described above. "Accrued" is replaced with "assessed" to match the terminology in other sections for consistency. Hospitals receive notice of an "assessed" penalty, which can include penalties for identified violations and accrued late

penalties. “And” is replaced with “or” because a penalty can be assessed for a violation of the Hospital Fair Pricing Act *or* the regulations, whereas “and” can be misinterpreted to require a violation of the Act and the regulations for a penalty to be assessed. And “shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). To eliminate repetitiveness and be more concise, subdivisions (a)(1) and (a)(2) are repealed and the relevant language is combined, shortened, and added to the end of subdivision (a). The direct address is removed to avoid having to amend the regulations whenever the Department moves and to mirror language of other units within the Department.

Subdivision (b): Existing subdivision (b) is amended to add language that a specific form is not required to request a hearing, but an optional form is available for download on the Department’s website. This is necessary to make clear that any written request can be made, but for convenience and ease, an optional form is available that requests the information required by the regulations. And “shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivisions (b)(1) and (b)(2): Existing subdivisions (b)(1) and (b)(2) remain unchanged.

Subdivision (b)(3): Existing subdivision (b)(3) is amended to add “if applicable.” The existing regulations were written to only address appeals of patient complaints but need to be amended to apply to all appeals. An appeal of a penalty assessed as a result of a policy review would not be tied to a patient complaint, so information about the patient who filed the complaint will not always be applicable.

Subdivision (b)(4): Existing subdivision (b)(4) is amended to replace “penalty assessment notice” with “administrative penalty notice,” which is the terminology currently used by the Department.

Subdivision (b)(5): New subdivision (b)(5) is added to require hospitals to include the penalty number and individual violation numbers of the penalty assessment being appealed. This is so the Department knows which specific violations the hospital disputes, reduces the issues on appeal to only those that need to be resolved with a hearing, and allows separate payment of the non-appealed violations (instead of delaying the total payment until the end of the appeal).

Subdivision (b)(6): Existing subdivision (b)(5) is renumbered to (b)(6) as a result of the amendment above, and the text is amended to help narrow the focus of the appeal. In addition to a statement of the basis for the appeal, hospitals must identify the component of the penalty assessment being challenged, which could be the existence of the violation, the classification, or the reasonableness of the penalty, which will be described further in section 96051.36.

Subdivision (b)(7): Existing subdivision (b)(6) is renumbered to (b)(7) as a result of the amendment above, and the word “administrative” is added for consistency.

Subdivision (c) New subdivision (c) is added to clarify that any violation listed in a penalty assessment but not appealed must be paid within 30 calendar days from the date the notice was issued. This will prevent the delay of payments for penalties that are not disputed.

Subdivision (d): New subdivision (d) is added to make clear that any legal or factual basis for appeal which is not stated in a timely filed appeal or timely filed supporting statement, will be deemed waived. This is necessary to put the hospital on notice that anything not raised in the appeal will be deemed accepted by the hospital and that only the issues specified will be addressed to save time and litigation costs.

Subdivision (e): Existing subdivision (c) is renumbered to (e) as a result of the amendments above and “shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Section 96051.36

New section 96051.36 is added to set limits on the issues on appeal. This is necessary to keep appeals focused and reduce costs associated with time spent discussing issues not in dispute.

Subdivision (a): New subdivision (a) is added to clarify that the issues on appeal are limited to those arising out of the facts set forth in the Department action, and the grounds set forth in the appeal. This is necessary to set the boundaries of the appeal.

Subdivision (b): New subdivision (b) is added to require the hospital to specify which of the outlined components are being challenged for each penalty assessment and violation number. A penalty assessment can be made up of multiple violations, and appeal reasons could vary for different violations. Specifying the “why” for each individual violation will help keep the appeal organized and the issues focused. Subdivision (b)(1) through (b)(3) identify the different components of the penalty that can be appealed. The hospital can appeal the existence of the violation, the classification of the violation, or the reasonableness of the penalty, which consider the penalty adjustment factors.

Subdivision (c): New subdivision (c) is added to clarify that if the appeal contests only the reasonableness of the penalty, the issues on appeal will be limited to the classification of the violation and the reasonableness of the penalty. If only the reasonableness of the penalty is challenged, then it is presumed that the hospital does not dispute the existence of the violation, and that issue does not need to be litigated.

Subdivision (d): New subdivision (d) is added to clarify that if a violation is classified as a Repeat violation, the earlier penalty established by failure to appeal or the entry of a final decision by the Director will not be in issue. The previous violation which creates the “repeat” violation is already established and time does not need to be wasted relitigating the issue.

Section 96051.37

New section 96051.37 is added to clarify that the 30-day deadline to take corrective action required by the Department in an administrative penalty notice is stayed upon the filing of an appeal with the Department and remains stayed until withdrawal of the appeal or a final decision of the proceeding by the Director. This is necessary so the hospital knows what to expect during an appeal.

Section 96051.38

Existing section 96051.33 is renumbered to section 96051.38 as a result of the amendments above.

Subdivisions (a), (a)(1), and (a)(2): Existing subdivisions (a), (a)(1), and (a)(2) are amended to replace “shall” with “must” (see the explanation of proposed amendments to section 96051.1(c) above) and update internal section references to the newly renumbered sections. This is a non-substantive change.

Section 96051.39

Existing section 96051.34 is renumbered to section 96051.39 as a result of the amendments above.

Subdivision (a): Existing subdivision (a) is amended to add “if applicable” since the hearing officer will only need to notify the patient who filed the complaint if the appeal is about a patient complaint.

Subdivision (b): Existing subdivision (b) is amended to replace “shall” with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (c): New subdivision (c) is added to introduce and separate the issues related to patient complaints for clarity.

Subdivision (c)(1): Existing subdivision (c) is moved and renumbered to (c)(1) as a result of the amendment above. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Additional language is added to clarify that in situations where the penalties assessed are unrelated to the issues of the patient’s complaint, then the patient does not need to be given 30 calendar days to review exhibits and provide a response and additional evidence. For example, if a patient filed a complaint about an eligibility determination that the Department found to be in compliance, but the Department discovered during the investigation that the hospital did not have the required wall postings and assessed a penalty for that violation, a response from the patient on that issue would only be an opinion that would not be relevant to the hearing since it was not something the patient raised or had personal knowledge of.

Subdivision (c)(2): Existing subdivision (d) is moved and renumbered to (c)(2) as a result of the amendments above since it is tied to (c)(1). “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (d): Existing subdivision (e) is renumbered to (d) as a result of the amendments above. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Subdivision (e): Existing subdivision (f) is renumbered to (e) as a result of the amendments above. Text remains unchanged.

Subdivision (f): Existing subdivision (g) is renumbered to (f) as a result of the amendments above. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above). Text of subdivisions (f)(1) and (f)(2) remain unchanged.

Subdivision (g): Existing subdivision (h) is renumbered to (g) as a result of the amendments above. Text remains unchanged.

Subdivision (h): Existing subdivision (i) is renumbered to (h) as a result of the amendments above. “Shall” is replaced with “must.” (See the explanation of proposed amendments to section 96051.1(c) above).

Section 96051.40

Existing section 96051.35 is renumbered to section 96051.40 as a result of the amendments above.

Subdivisions (a) to (e): Existing subdivisions (a) to (e) are amended to replace “shall” with “must” or “will.” (See the explanation of proposed amendments to section 96051.1(c) above). Internal section reference in subdivision (d) is amended to the newly renumbered section.

Subdivision (f): Existing subdivision (f) is amended to add clarifying language that only exhibits, documents, and information related to an appeal of a patient complaint investigation are deemed confidential. Appeals relating to a policy review would not involve private information that needs to be protected, and the exhibits, documents, and information would not be confidential.

Section 96051.41

Existing section 96051.36 is renumbered to section 96051.41 as a result of the amendments above. “Shall” is replaced with “must” or “will.” (See the explanation of proposed amendments to section 96051.1(c) above).

Section 96051.42

Existing section 96051.37 is renumbered to section 96051.42 as a result of the amendments above. “Shall” is replaced with “must” or “will.” (See the explanation of proposed amendments to section 96051.1(c) above).

V. TECHNICAL, THEORETICAL, OR EMPIRICAL STUDY, REPORTS, OR SIMILAR DOCUMENTS RELIED UPON

In developing the proposed changes, the Department relied upon the following documents:

1) Web Content Accessibility Guidelines (WCAG) 2.2, World Wide Web Consortium (W3C), https://www.w3.org/TR/WCAG22/ (accessed February 18, 2025).

2) PDF Techniques for WCAG 2.0, World Wide Web Consortium (W3C), https://www.w3.org/TR/WCAG20-TECHS/pdf (accessed May 5, 2025).

3) Document Accessibility Standards 1.0, Department of Rehabilitation, June 2019, https://publicaccessstorage.blob.core.usgovcloudapi.net/publicsitefiles/DOR%20Documents/Disability%20Access%20Services/DOR%20Document%20Accessibility%20Standards%20June%202019.pdf.

4) Understanding Accessible Fonts and Typography for Section 508 Compliance, U.S. General Services Administration, https://www.section508.gov/develop/fonts-typography/ (accessed April 15, 2025).

5) Supplemental Guidance: Text Justification, W3C Low Vision Accessibility Task Force, https://www.w3.org/WAI/GL/low-vision-a11y-tf/wiki/Supplemental_Guidance:_Text_Justification (accessed April 15, 2025).

6) Learn the 7 Core Accessibility Skills – Tables, University of Minnesota, https://accessibility.umn.edu/getting-started/learn-7-core-accessibility-skills/tables (accessed May 8, 2025).

7) State Enforcement Actions Dashboard, California Department of Public Health, https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/StateEnforcementActionsDashboard.aspx (accessed April 15, 2025).

8) Threshold and Concentration Languages for All Counties as of March 2024, Department of Health Care Services, March 2025, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/Threshold-and-Concentration-Languages-for-All-Counties.pdf.

9) Senate Committee on Health, Analysis of Senate Bill 862 (2025-2026 Reg. Sess.), April 28, 2025,

https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202520260SB862#).

VI. ECONOMIC IMPACT ASSESSMENT

Creation or Elimination of Jobs Within the State

The Department does not anticipate any impact on the creation or elimination of jobs. The proposed regulatory action specifies and updates the Department's administrative procedures and adds clarification to existing hospital fair billing requirements. As a result, demand for hospital bill financial assistance is not expected to increase or decrease because of this proposed regulatory action. No significant new tasks are created by the proposed regulatory action, and it is not anticipated that any jobs engaging in this work will be affected.

Creation, Elimination, or Expansion of Existing Businesses Within the State

The Department does not anticipate any impacts on the creation of new businesses, the elimination of existing businesses, or the expansion of existing businesses. The proposed regulatory action specifies and updates the Department's administrative procedures and adds clarification to existing hospital fair billing requirements that are already widely practiced. There is no reason to believe these regulations will increase the number of hospitals doing business and there is nothing in the proposed regulatory action that would promote or require additional hospitals to open. The proposed regulatory action does not impose new duties or burdens on hospitals, so it is unlikely that a hospital would close as a result of the proposed changes. The proposed regulatory action would not increase the number of hospital patients, so it would not affect the expansion of hospitals currently operating in the state.

Benefits of the Regulation to the Health and Welfare of California residents, Worker Safety, and the State's Environment

Overall, the proposed regulatory action improves clarity and consistency to make it easier for hospitals to comply with the Hospital Fair Pricing Act, which benefits the health and welfare of California residents. The proposed regulatory action will also benefit the health and welfare of California residents by further clarifying hospital financial assistance policy and application requirements and improve readability of those documents so patients may better understand their rights and protections. This regulatory action also strengthens and clarifies how administrative penalties are assessed to promote hospital compliance with the requirements of the Hospital Fair Pricing Act, which benefits patients.

By eliminating the hardcopy notice requirement, there may be minimal benefit to the environment by saving paper.

No benefits to worker safety are anticipated because the proposed regulatory action does not involve worker safety.

Impact on Individuals

The Department is not aware of any cost impacts that a representative private person would necessarily incur in reasonable compliance with the proposed action. The only individuals impacted by this action are hospital patients. Burdens or obligations on the patient side are not increased by any of the proposed changes.

VII. EVIDENCE SUPPORTING FINDINGS OF NO SIGNIFICANT ADVERSE ECONOMIC IMPACT OF ANY BUSINESS

Although the proposed action *will* directly affect businesses statewide, the Department concludes that the economic impact, including the ability of California businesses to compete with businesses in other states, *will not* be significant.

The only businesses impacted by these regulations are hospitals. Hospitals, by their nature, are generally location centric and are not competing with businesses within or outside the state.

These regulations will potentially increase the final penalty assessment amount for patient complaint investigations with the modifications to the base penalty structure and adjustments. However, administrative penalties for patient complaint investigations are subject to a statutory maximum of $40,000 under Health and Safety Code section 127436(b)(4), so the overall impact ultimately remains unchanged. In addition, hospitals that comply with the statutory and regulatory requirements are not subject to penalties and will not incur that cost.

These regulations may require some hospitals to incur a cost to reprint wall postings if their postings are not compliant with the modified requirements. Some hospitals are already compliant with the proposed regulations and would not incur any cost as a result. The Department estimates it costs $0.38 to print one posting. The existing regulations specify that these postings must be printed on 11” x 17” paper. The Department sourced the cost of commercially available 11” x 17” copy paper which is $17.49 per ream of 500 sheets, at a cost of $0.035 per sheet ($17.49 ÷ 500 = $0.035). The Department also sourced the cost of commercially available toner for a copy machine at $160 per toner cartridge which yields 59,000 pages at a cost of $0.003 per page ($160 ÷ 59,000 = $0.003). Together, that is a cost of $0.038 per posting ($0.035 + $0.003 = $0.038). The postings must be displayed in the hospital’s emergency department, billing office, admissions office, and other outpatient settings, including observation units, and hospitals typically use one posting per required area. Estimating high and assuming a hospital needed ten postings, that would cost $0.38 per hospital ($0.038 × 10 = $0.38). For the 529 hospitals regulated by the proposed package, that would cost $201.02 statewide ($0.38 × 529 = $201.02). Of note, existing hospitals already have supplies to comply with the existing requirements, so this would be an absorbable cost.

This would be the initial cost to comply with the modified requirements. Annual on-going costs are unknown but likely minimal. Once a hospital's postings are compliant with all requirements, a hospital will only need to reprint the posting if the hospital changes the information (like updating a phone number or a logo), or if a posting is damaged or removed and needs to be replaced.

While there may be some cost involved in reprinting wall postings, this should be easily offset by the savings created by the elimination of the requirement that every notice required by Health and Safety Code section 127410(a) be provided in hardcopy. According to Stanford Health Center's tracking data, in 2024 alone, they printed a total of 846,813 notices at a cost of $575,823.84, which is $0.68 per notice ($575,823.84 ÷ 846,813 = $0.68). The amount of overall savings is unknown, but it is presumed to be significant to warrant hospitals seeking legislative change to add statutory language to limit hardcopy notices. In addition, significantly more notices are printed than wall postings since notices are provided to every patient, so it is safe to assume reducing the number of notices printed is going to result in an overall saving.

In addition, the 2024 biennial policy review is still on-going, and hospitals are still revising noncompliant postings, so any additional reprinting should be an absorbable cost by existing businesses and should not result in either a substantial change in their existing business practices or their elimination. For any new hospitals that open, this regulatory action does not add any additional costs than what was already required under the existing regulations.

Under Government Code section 11342.610(b)(11), "small business" does not include "A health care facility exceeding 150 beds or one million five hundred thousand dollars ($1,500,000) in annual gross receipts." The most recent data set of hospital annual financial data reported to the Department shows zero hospitals with less than $1,500,000 in annual gross receipts, so no hospitals are small businesses, and these regulations will not have an effect on small businesses.[5]

For the reasons above, the proposed regulations will not have a significant adverse economic impact on business, and the net impact of the proposed amendments is a cost-savings to California businesses.

VIII. ALTERNATIVES CONSIDERED

No reasonable alternatives have been identified by the Department or have otherwise been identified and brought to its attention that would be less burdensome and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the authorizing statute or other law being implemented or made specific by the proposed regulation.

[5] 2022 – 2023 Fiscal Year Hospital Annual Financial Data (August 2024 Extract), https://data.chhs.ca.gov/dataset/hospital-annual-financial-disclosure-report-complete-data-set.

One alternative is to take no action and leave the regulations unchanged. This alternative was rejected because statutory changes require some regulatory changes, and the changes increasing clarity in the procedures and requirements will be helpful to hospitals to ensure compliance. To not fully specify the Department's procedures and compliance standards would leave in place less detailed standards and procedures, which is not a less burdensome and equally effective alternative that would achieve the purpose of the regulation in a manner that ensures full compliance with the law.

Another alternative is to make the regulations less prescriptive. This alternative was rejected because it would likely reduce clarity and consistency with hospital compliance and hospital output (i.e., policies, application, postings, notices, etc.). The goal of the proposed action (and existing regulations) is to make hospital financial assistance programs more uniform to make it easier for patients to understand. Using less prescriptive standards would have the opposite effect, which is not a less burdensome and equally effective alternative that would achieve the purpose of the regulation in a manner that ensures full compliance with the law.

The Department has not identified any reasonable alternatives that would lessen any adverse impact on small business because the proposed changes are clarifications and updates that impact the Department's administrative procedures that have no potential for economic impact on small businesses, and this regulatory action does not impose any new burdens than what hospitals are currently subject to.