Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
TITLE 22, CALIFORNIA CODE OF REGULATIONS
Division 7, Health Planning and Facility Construction

INITIAL STATEMENT OF REASONS

HOSPITAL FAIR BILLING PROGRAM

Pursuant to Government Code section 11346.2, the Director of the Department of Health Care Access and Information (Department) submits this Initial Statement of Reasons in support of the proposed repeal of sections 90640, 96041, 96042, 96043, 96044, 96045, 96046, and 96050 of title 22 of the California Code of Regulations (CCR) and in support of the proposed adoption of sections 96051, 96051.1, 96051.2, 96051.3, 96051.4, 96051.5, 96051.6, 96051.7, 96051.8, 96051.9, 96051.10, 96051.11, 96051.12, 96051.13, 96051.14, 96051.15, 96051.16, 96051.17, 96051.18, 96051.19, 96051.20, 96051.21, 96051.22, 96051.23, 96051.24, 96051.25, 96051.26, 96051.27, 96051.28, 96051.29, 96051.30, 96051.31, 96051.32, 96051.33, 96051.34, 96051.35, 96051.36, and 96051.37 of title 22 of the CCR.

I. INTRODUCTION

The Department's mission is to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. While the Department has several program areas, notably for purposes of this regulation package, the Department collects, manages, and reports information about California's healthcare infrastructure and patient outcomes.

In 2006, California passed the hospital fair pricing policies statutes, which required hospitals to offer charity care and discount payment (together financial assistance) to uninsured and underinsured patients below 350 percent of the Federal Poverty Level. It also required transparency in how patients could qualify for and apply for financial assistance, requiring hospitals to submit their policies and applications (together policies) for posting. While the Department, formerly known as the Office of Statewide Health Planning and Development, was tasked with collecting hospital documents and posting them online, enforcement of the law was placed with the California Department of Public Health (CDPH) which licenses hospitals in California. Since 2008, the

Department has collected the hospital's charity care and discount payment policies and posted them on its website.

Signed into law in 2021, Assembly Bill 1020 (Chapter 473, Statutes of 2021) (AB 1020), seeks to expand the number of patients eligible for financial assistance, increase protections for eligible patients, and strengthen state enforcement and oversight of the Hospital Fair Pricing Act.[1] To that end, AB 1020 placed enforcement authority with the Department starting January 1, 2024.

II. AUTHORITY

Health and Safety Code (HSC) section 127010 grants the Director of the Department the powers outlined in Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code. Government Code section 11152 specifically grants the head of each department the ability to adopt rules and regulations that are necessary to govern the activities of the department.

Health and Safety Code section 127435 grants the Department authority to collect, review, and post hospital policies outlined by that section.

Health and Safety Code 127436 grants the Department authority to accept and review patient complaints regarding hospital discount payment programs, charity care programs, and debt collection practices, as well as determine whether a violation has occurred, issue penalties, and establish an appeal process for hospitals.

III. SPECIFIC PROBLEMS ADDRESSED AND NECESSITY OF REGULATIONS

A. Background

AB 1020 expands the Department's existing hospital financial assistance policy collection and review efforts, tasks the Department with creating a patient complaint process for violations of the Act, and assess penalties for violations, including an appeals process. The Department is specifically required to promulgate regulations for the enforcement of Article 1 of Chapter 2.5, Part 2, Division 107 of the Health and Safety Code (Act) and commence enforcement by January 1, 2024. The proposed regulations are necessary to implement and administer the newly amended Act.

The Department's program for implementing the Act and proposed regulations is called the Hospital Fair Billing Program. The Department's public facing program for receiving and investigating patient complaints is called the Hospital Bill Complaint Program.

[1]Assembly Committee on Judiciary, Analysis of Assembly Bill 1020 (2021-2022 Reg. Sess.), as amended March 30, 2021, pp. 6-7.

B. Overview of Proposed Regulation

The Department is proposing this regulatory action to implement, interpret, and make specific Article 1 (Hospital Fair Pricing Policies, §§ 127400-127446) of Chapter 2.5, Part 2, Division 107 of the Health and Safety Code.

This rulemaking package first proposes a full repeal of title 22, CCR sections 90640 through 96050, in order to make the regulations consistent with the newly developed and proposed oversight processes.

The proposed regulations codify the Department's new processes for: collection and review of hospital policies and applications, receipt and review of patient complaints, assessment of penalties, and hospital appeal process. The proposed regulations further implement the goals of AB 1020 by clarifying requirements related to accessibility, patient eligibility, patient notice, and hospital oversight.

C. Problem, Purpose, and Necessity of Proposed Regulation

Amended Text Chapter Title

Current Title 22, Chapter 9, Article 2 is being repealed. As such, the title of Chapter 9 is being amended as it no longer includes requirements related to fair pricing policies reporting. This is necessary for clarity of Chapter 9.

Repealed Article 2 of Chapter 9

Current title 22, CCR sections 90640, 96041, 96042, 96043, 96044, 96045, 96046, 96050, along with their Article heading, are being proposed for repeal. These sections correspond with the Department's existing structure for collecting and reviewing hospital policies, which will be out of date with the Department's processes starting January 1, 2024. Repealing these sections will allow the Department's regulations to be updated to reflect the new processes and requirements following AB 1020 and eliminate confusion by removing out of date information from the regulations.

§ 96040

Current subdivision (a) is not consistent with Health and Safety Code section 127400 (d). As the new definition of section 95651 references the statutory definitions, it is unnecessary to duplicate the definition of "hospital" in regulation.

Current subdivision (b) is out of date as the Office of Statewide Health Planning and Development is now the Department of Health Care Access and Information. It is therefore necessary to repeal this definition to avoid confusion.

Current subdivision (c) is the definition of discount payment. It is being repealed as the terms of the discount payment program are outlined in statute and the definition is unnecessary.

§§ 96041, 96044, 96045

Current sections 96041, 96044, and 96045 repeat statutory requirements for policy and application submission. These are being repealed as it is unnecessary to repeat the requirements. Where implementation of the statute is necessary by regulation, those requirements are being moved to section 96051.6. Further, the definition of "significant change" outlined in these sections is being revised in the proposed regulation 96051.6(b)(5) for clarity.

§§ 96042, 96043, 96046

Current sections 96042, 96043, and 96046 outline procedures for submitting documents to the Department which will be outdated as of January 1, 2024. Where implementation of the statute is necessary by regulation, those requirements are being updated and moved to section 96051.6.

§ 96050

Current section 96050 is being repealed as the Department will not accept alternate file types or methods of submission. The technology and file types required by the Department in the newly proposed regulation are readily accessible. The requirements are being updated and moved to section 96051.6. Therefore, repeal is necessary for clarity and to prevent confusion.

Proposed Text

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

§ 96051. Definitions

This section defines terms used in the Act and Articles 1 through 6 of Division 7, Chapter 9.2 of title 22 (proposed regulations). It is necessary to define the terms that were previously undefined or unclear to assist hospitals in implementing the law and regulations and to assist patients in understanding their rights under the current law. This will increase the likelihood that hospitals are able to successfully comply with the law and regulations and patients will be more likely to benefit from the rights provided by the Act.

Subdivision (a) defines "Act" to mean HSC sections 127400 through 127446, inclusive. This provision is necessary to conveniently clarify the statutory provisions being referenced throughout the proposed regulation text without having to use a lengthy title.

Subdivision (b) defines "charity care" as free or discounted hospital care and services provided to patients who meet the hospital's eligibility criteria under the hospital's charity care policy. This provision is necessary to clarify that charity care may be free or discounted care and that patient eligibility for charity care is based on the criteria listed

in a hospital's financial assistance policy, ensuring a consistent understanding of the requirements of charity care for both hospitals and patients.

Subdivision (c) defines "Director" as the Director of the Department of Health Care Access and Information. This provision is necessary to clarify the identity of the Director referenced in the proposed regulations.

Subdivision (d) defines "policy" or "policies" as the document or documents the hospitals are required to submit pursuant to HSC section 127435 (a). This provision is necessary to clarify which documents are being referenced in the proposed text.

Subdivision (e) defines "working days" as Monday through Friday, not including State Holidays. This provision is necessary to clarify due dates and timelines, especially because hospitals provide medical services 24 hours per day and 7 days per week, but many administrative functions are handled only on weekdays.

§ 96051.1. Document Accessibility

This section specifies the accessibility requirements for all documents hospitals provide patients under the Act. AB 1020 created new notice requirements for hospitals regarding informing patients about discount payment and charity care. These accessibility requirements are necessary to prevent discrimination and ensure all patients can access information related to hospital discount payment and charity care, as well as the Department's Hospital Bill Complaint Program.

Subdivision (a) states the following accessibility requirements apply to all hospital documents provided to a patient under the Act and proposed regulations. Subsequent related subdivisions, (a)(1) through (a)(6), lay out the specific requirements.

Subdivision (a)(1) explains that all hospital documents must be designed and presented in a way that is easy to understand by a patient. This provision is necessary because a hospital document will have no utility to a patient if they are not able to read or understand its content. A "reasonable person" standard is used here, as further described in the following subdivisions.

Subdivision (a)(2) explains all hospital documents must use a sans serif font in at least 12-point size, with section headings in a larger font size or bold/underlined font style to distinguish different sections of the document. The Department relies on the Department of Rehabilitation guidelines for accessibility in this regard, which is a state standard.[2] A 12-point size font for body text is generally accepted as an accessible font size, whereas smaller font sizes may be illegible for some patients.[3] Sans serif fonts

[2] DOR Accessibility Standards 1.0, https://publicaccessstorage.blob.core.usgovcloudapi.net/publicsitefiles/DOR%20Documents/Disability%20Access%20Services/DOR%20Document%20Accessibility%20Standards%20June%202019.pdf

[3] *Id*. at p. 3-4.

(such as Arial) also typically have higher readability than serif fonts (such as Times New Roman), which have decorative strokes that can confuse screen readers and persons with reading challenges.[4] Section headings are recommended for better comprehension and readability, including with a screen reader.[5]

Subdivision (a)(3) explains hospital documents must be written in plain and straightforward language that avoids technical jargon. This provision is necessary so hospitals will use simple language that will allow patients to understand the information provided about discount payment, charity care, and the Hospital Bill Complaint Program. Plain language requirements are also specified by the Federal Plain Writing Act of 2010, Public Law 111-274, and California Government Code Section 6219 (a) through (b).

Subdivision (a)(4) explains hospital documents must include information on how a patient with a disability may access the document in an alternative accessible formant, including, but not limited to, large print, braille, audio, and other accessible formats such as with a screen reader, which must be able to read the document in a logical (sequential) reading order. This provision is necessary to prevent discrimination and ensure all patients have access to the provided information.

Subdivision (a)(5) explains that the hospital document must provide information on how a patient may access the document's information in languages other than English. This provision is necessary to prevent discrimination against limited English proficient patients.

Subdivision (a)(6) explains hospital documents must be provided in languages other than English if the hospital meets the population threshold for a non-English language, in compliance with HSC section 127410 (a). This provision is necessary to prevent discrimination against limited English proficient patients and ensure all patients have access to the provided information as required by existing state and federal law. Because hospitals are currently required in many instances to comply with language provisions, hospitals already have systems in place for translating documents and for determining in what language a patient is best served (often by a card or page where a patient points to the language they best recognize).

§ 96051.2. Eligibility Letter

This section specifies the requirements for hospital eligibility determination letters, so patients can understand whether the hospital has approved or denied their application

[4] What are Accessible Fonts, https://www.accessibility.com/blog/what-are-accessible-fonts.
[5] DOR Accessibility Standards 1.0 at p. 5, https://publicaccessstorage.blob.core.usgovcloudapi.net/publicsitefiles/DOR%20Documents/Disability%20Access%20Services/DOR%20Document%20Accessibility%20Standards%20June%202019.pdf

for discount payment or charity care. This section also clarifies that if a patient is approved for discount payment or charity care, the hospital's eligibility letter to the patient shall include information regarding their revised financial responsibility.

Subdivision (a) explains hospital eligibility determination letters shall have specific requirements regarding their content, which is specified in related subdivisions (a)(1) through (a)(6).

Subdivision (a)(1) states the eligibility letter must include a clear statement of the hospital's eligibility determination. The purpose of this subdivision is to ensure patients know the hospital's discount payment and/or charity care determination. This is necessary for the patient to understand whether their application for discount payment and/or charity care was approved or denied. The Act includes notice requirements regarding discount payment and charity care, as well as the Hospital Bill Complaint Program, and a patient cannot know whether they may need to file a complaint with the Hospital Bill Complaint Program unless they are notified of the hospital's eligibility determination.

Subdivision (a)(2) states if a patient was denied discount payment and/or charity care, the hospital must include a clear statement explaining why the patient was denied. This is necessary for transparency because if a patient is denied discount payment and/or charity care but is not provided with information regarding why they were denied, the patient does not have all the necessary information to determine whether they will want to file a complaint with the Hospital Bill Complaint Program.

Subdivision (a)(3) explains if a patient was approved for discount payment or charity care, the hospital shall provide a clear explanation of the reduced bill and instructions on how the patient may obtain additional information regarding their reasonable payment plan. This is necessary so patients can understand their ongoing financial responsibility to the hospital and have the information necessary to make appropriate payments.

Subdivision (a)(4) states the eligibility letter shall include the name of the hospital office, contact name, and contact information where the patient may appeal the hospital's decision. This is necessary so patients know how they may obtain more information about their eligibility determination. AB 1020 is silent regarding a deadline to file discount payment and/or charity care applications. At this time, the proposed regulations do not include a discount payment or charity care application period. As the Hospital Bill Complaint Program is implemented and experience gained regarding patient appeals, the Department may consider adding additional requirements regarding the application period or a deadline to file Hospital Bill Complaint Program complaints.

Subdivision (a)(5) states the eligibility letter must include information on the Hospital Bill Complaint Program. This is necessary so patients are informed that if they believe they were improperly denied discount payment or charity care, they may file a complaint with

the Hospital Bill Complaint Program. The reference to section 96051.3 is a convenience so that a hospital has a full list of what must go in each letter.

Subdivision (a)(6) states the eligibility letter shall include information on Health Consumer Alliance. This is necessary because Health Consumer Alliance will aid patients with their applications, as well as with understanding their eligibility for other county and state programs. The Act states information for Health Consumer Alliance shall be included on hospital notices, therefore it is appropriate and convenient to also include this information in hospital eligibility determination letters. The specific text requirement for hospitals to provide to patients was chosen to be concise and consistent among all hospitals.

§ 96051.3. Hospital Bill Complaint Program Notice

The purpose of this section is to ensure patients have notice about the Hospital Bill Complaint Program. This section explains all notices provided to a patient under the Act, as well as all billing statements, shall include a statement about the Hospital Bill Complaint Program. HSC section 127410 requires that hospitals provide patients with notice about hospital discount payment and charity care because in the past patients may not have been aware of available hospital financial assistance options. The Hospital Bill Complaint Program is a state program for patients who may have been improperly denied financial assistance. Accordingly, this section is necessary because in addition to notice about hospital discount payment and charity care, patients must have notice about the Hospital Bill Complaint Program. This section includes specific prescriptive language that hospitals must use in their documents and billing statements. This is necessary so messaging about the Hospital Bill Complaint Program is complete and consistent for all patients.

§ 96051.4. Hospital Delegation

The Department is aware that some hospitals contract with outside entities to perform functions required by the Act, such as review and determine eligibility for financial assistance. This means that hospitals may not have direct control over ensuring compliance with the Act and regulations, but that does not abrogate their responsibility.

Proposed section 96051.4 specifies that when the hospital delegates any of its obligations under the Act or the proposed regulations, the hospital remains responsible for compliance with the Act and its corresponding regulations. This is necessary to notify hospitals that the Department will pursue penalties against hospitals for failures of their delegates to comply with the applicable laws and regulations and therefore motivate hospitals to oversee their delegates and ensure compliance with the Act and proposed regulations.

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

§ 96051.5. Hospital Contact and Registration for Policy Submission

Under HSC section 127435, hospitals are required to submit policies and application forms to the Department for review. In order to maintain contact with hospital representatives regarding this requirement and their policies, the Department needs to collect and maintain contact information for hospital representatives. Further, hospital representatives need to register in the Department's online system for submission of the required documents. These requirements will ensure review of hospital policies as required by the Act.

The online policy submission portal, and process for registering in that system, is currently utilized by other Departmental programs. As such, hospitals are familiar with registering in the system. The regulations in this section were drafted to be substantially similar to those existing Departmental regulations and therefore should not be a burden on hospitals to use.

The Department acknowledges that requiring the hospitals to utilize its online policy submission portal, as outlined in proposed sections 96051.5 and 96051.6, is a prescriptive standard. While the Department considered accepting policies through other means chosen by individual hospitals, this would make the process for collecting, reviewing, and posting the policies very difficult and burdensome on the Department and might cause hospitals to incur costs related to copying and mailing documents. By utilizing the online policy submission portal, the Department can utilize its limited resources efficiently, and effectively track, review, and post policies as required by HSC section 127435.

Subdivision (a) specifies that hospitals must designate a primary and secondary contact for the Department to communicate with regarding hospital policies. This is necessary to ensure that the Department can contact the appropriate individual at the hospital regarding the policies. In addition, a secondary contact is necessary to ensure that the Department may reach the hospital in the case that the primary contact is not responsive (for instance, on vacation or medical leave).

Subdivision (b) specifies that the hospital's primary and secondary contacts must each register in the Department's online system by providing the information requested in subdivisions (b)(1) through (b)(7). This is necessary to ensure the Department has the means to contact hospitals regarding policies and hospitals can submit documents through the online policy submission portal as required by HSC section 127435.

Subdivisions (b)(1) through (b)(6) specify the contact information the primary and secondary contacts must provide. This is necessary for the Department to contact each hospital regarding the policies they are required to submit pursuant to HSC section 127435 (a).

Subdivision (b)(7) specifies that the contact shall indicate whether they are the primary or secondary contact. This is necessary for the Department to know who to initially contact with all communications, as the secondary contact will only be utilized for communication when the primary contact is non-responsive to the Department.

Subdivision (c) specifies the timeline for changes to the hospital's designated contacts or their contact information outlined in subdivision (b). This is necessary to ensure the Department can have timely communications with hospitals regarding their policies. A 10-working day timeframe for providing this information gives the hospital a reasonable time to report changes but also ensures that the Department can contact hospitals regarding compliance issues with their policies which could impact patient eligibility for the charity care and discount payment programs.

§ 96051.6. Hospital Policies

Under HSC section 127435, hospitals are required to submit policies and application forms (together policies) to the Department for review. This section clarifies the processes for hospital submission, the document requirements, the Department's review process, and substantive requirements to ensure hospitals are informed about how and when to submit their documents and what to include.

Subdivision (a)(1) requires each policy submitted by hospitals to include an effective date. This is necessary to ensure that the Department posts the correct version of the policy on its website and to assist patients in identifying the policy that is relevant to their bill.

Subdivision (a)(2) clarifies that charity care and discount payment policies shall include eligibility determination procedures and the hospital's review process. The requirement for hospitals to submit eligibility procedures and the hospital's review process is in HSC section 127435. This clarification is necessary to ensure the information is submitted and accessible in a consistent manner.

Subdivision (a)(3) clarifies various statutory procedures that must be included in the hospital's debt collection policy. This is necessary to ensure hospitals follow all the statutory requirements. By listing these statutes in this regulation, there will be less likelihood that a hospital will miss or overlook the enumerated requirements.

Subdivision (b)(1) specifies the primary or secondary contact from the hospital shall submit the policies required by HSC section 127435 and provides the due date for submission. While HSC section 127435 requires a biennial submission, requiring submission by January 1, 2024, comports with the existing timeline which the hospitals have been required to follow since 2008 pursuant to 22 CCR 96041, which is proposed for repeal. In addition, this subdivision outlines the procedure for submitting the required documents. This is necessary to clarify for hospitals when policy submission is required and the means by which they submit the policies to the Department.

Subdivision (b)(2) defines "reporting period" as the four-month period leading up to the biennial policy submission due date outlined in HSC section 127435 (a). This is necessary to clarify the timeline for submission for the hospitals and ensure the hospitals have sufficient time to submit the report in advance of the deadline.

Subdivision (b)(3) specifies that newly licensed hospitals are required to submit policies prior to treating patients. This is necessary to clarify the timing of policy submission for newly licensed hospitals and ensure that hospitals have compliant policies and procedures in place to meet the requirements of the Act and corresponding regulations when they accept patients.

Subdivision (b)(4) specifies that hospitals shall submit policies with significant changes to the Department, as required by HSC section 127435, via the Department's online portal. This is necessary to clarify for hospitals how they can meet the statutory requirements.

Subdivision (b)(5) defines significant change. This is necessary to clarify for hospitals when they need to submit revised policies as described in HSC section 127435. The Department drafted this definition to ensure that changes to policies that impact patient access to financial assistance or other protections will be reviewed for compliance by the Department. Making sure that hospital policies are compliant with the Act and proposed regulations supports a goal of AB 1020, which is to ensure that patients eligible under the Act can avail themselves of discount payment and charity care without legal representation.[6]

Subdivisions (b)(6)(A) and (b)(6)(B) outline the information hospitals are required to provide with each policy submitted to the Department. This is necessary to ensure that the Department posts the correct version of the policy on its website for each hospital and each facility under its license.

Subdivisions (b)(6)(C)(i) and (b)(6)(C)(ii) specify that the person submitting the documents must certify under penalty of perjury that they are duly authorized to submit the policies and that they are true and correct copies of the hospital's policies. This is necessary to have verification that the submitted policies are the policies the hospital uses or will use pursuant to the listed effective date. Certification under penalty of perjury helps to ensure that the documentation contains truthful, factual representations made in good faith. (See, e.g., *In re Marriage of Reese & Guy* (1999) 73 Cal.App.4th 1214, 1223 [judicial explanation for the use of certifications under penalty of perjury: "The whole point of permitting a declaration under penalty of perjury, in lieu of a sworn statement, is to help ensure that declarations contain a truthful factual representation and are made in good faith."] In addition, such certification helps ensure the reliability of the statements to the Department, since the act of certifying under penalty of perjury

[6] Assembly Committee on Judiciary, Analysis of Assembly Bill 1020 (2021-2022 Reg. Sess.), as amended March 30, 2021, p. 6.

can have a deterrent effect on those who many considering not providing true, accurate, or complete information.

Subdivision (c)(1) specifies the required file type for each policy the hospital submits to the Department. Sections 96042 and 96043, proposed to be repealed in this action, allowed for submission in both Microsoft Word (.doc) and Portable Document Format (.pdf). Because the Department currently accepts documents in two file types, in order to post the document through its online system in a consistent format, the Department had to convert the files to Portable Document Format (.pdf). This was an inefficient use of limited resources. Utilizing a single file type is necessary to ensure all hospital policies can be accessed by the Department and the public in a consistent file type that is readily accessible. This will ensure accessibility and ease of use for patients retrieving hospital policies from the Department's website. Further, the program to create documents in Portable Document Format (.pdf) is readily available to hospitals and does not create an additional expense for hospitals.

Subdivision (c)(2) specifies that the policies shall be searchable. This is necessary for patients and the Department to easily find information within the policies and relates to the accessibility of information.

Subdivision (c)(3) specifies that hospitals shall submit a clean version of the policy and a marked-up version of the policy which reflects changes since the policy was last submitted to the Department. The clean versions are necessary for the Department to post policies as required by HSC section 127435 and the marked-up versions are required for the Department to be able to identify and review changes to the hospital policies.

Subdivision (d)(1) specifies a 10-working day timeframe for hospitals to respond to Departmental communications regarding review of their policies. This is necessary to ensure that any compliance concerns raised in the policies are addressed quickly so that patients receive appropriate access to the charity care and discount payment programs while still giving hospitals a reasonable business response time.

Subdivision (d)(2) specifies that the hospital's responses to Department communications should be complete. This is necessary to clarify that partial or incomplete responses may be subject to penalties as outlined in proposed section 96051.22.

Subdivision (d)(3) specifies that hospitals shall submit revised policies in response to Department comments in the same manner and form as in (b)(3). The same necessity applies in this subdivision.

Subdivision (d)(4) specifies that the hospital may request an extension if it cannot provide a response to Department correspondence within 10-working days. This is necessary to allow hospitals additional time in the case that they cannot in good faith meet the deadline.

Subdivision (d)(5) specifies that the Department may grant an extension request depending on a number of listed factors. This is necessary to provide a basis for the Department's determination and to advise the hospital of what they may need to show to obtain an extension.

Subdivision (d)(5)(A) indicates the Department will consider the complexity of the required response from the hospital. This is necessary to consider how much time the hospital will need for the required response and allow the Department to grant extra time if it is a complex response that will require additional time.

Subdivision (d)(5)(B) indicates the Department will consider the hospital's history of cooperativeness. This is necessary to account for whether the hospital generally is responsive to the Department or whether the hospital is chronically difficult to work with and may reflect on the credibility of the hospital's request.

Subdivision (d)(5)(C) indicates the Department will consider necessity for a third party to assist the hospital in obtaining records. This is necessary to account for additional time the hospitals may need to obtain the needed records due to external factors not under their control.

Subdivision (d)(5)(D) indicates the Department will consider any other factors submitted by the hospital showing good cause. This is necessary to allow for other factors that the hospital may raise in support of their extension request.

Subdivision (d)(6) indicates that no penalty will apply if an extension is granted pursuant to proposed subdivision (d)(5). This is necessary to encourage hospitals to request an extension when they cannot meet the deadline for responding to the Department. By requesting the extension, the Department is on notice that the requested documents may be delayed rather than have the Department devote resources to checking on status or initiating penalty proceedings.

§ 96051.7. Discount Payment Program

Pursuant to HSC section 127405, hospitals are required to maintain an understandable written policy regarding discount payments for financially qualified patients. This section clarifies and implements statutory requirements related to the discount payment program, ensuring patient notice and protection of their rights under the Act, as well as consistency in how the programs operate across hospitals.

Subdivision (a) clarifies for hospitals and patients that medically necessary services, as determined by a patient's treating provider or referring provider, are eligible for discount payment to financially qualified patients. The section explains that services performed within the hospital are presumed to be medically necessary unless the hospital demonstrates with an attestation from a patient's treating provider or referring provider that the service was not medically necessary. The legislative history supports that the Act is intended to apply to medically necessary services. The Act's author states that the Act "will ensure individuals seek medical care when they need to (as opposed to

being scared to go to the hospital because of the bill they may get afterwards) and will care for those most vulnerable in our society, including the uninsured and under-insured."[7] Further, the legislative history of the original Hospital Fair Pricing Act, enacted in 2006 and amended by AB 1020 in 2021, also supports that discount payment provided by hospitals was intended to apply to medically necessary services. The original Hospital Fair Pricing Act's sponsor stated, "[T]his bill creates consumer and financial protections so that uninsured and underinsured families can get the hospital care they need without facing financial ruin."[8]

The Act is silent about what medical services qualify for discount payment eligibility. This silence could be interpreted to mean that no discount payment eligibility exceptions for any medical services would be permitted, including no discount payment eligibility exceptions for elective or cosmetic services. If no exclusions for services of any kind are allowed in hospital discount payment policies, patients who qualify under a hospital's discount payment policy would be eligible for elective and cosmetic services at low to no cost. This would likely have a negative impact on hospitals' financial and operational integrity and their ability to offer discount payment and charity care for services actually needed by uninsured and underinsured individuals. If hospitals are required to offer elective and cosmetic services at low or no cost to patients eligible for discount payment, they may stop offering these services entirely, which could create healthcare access issues for Californians.

The proposed text is necessary to ensure that hospitals do not exclude medically necessary services from discount payment eligibility, as the legislature intended. It also ensures that hospitals are not required to offer discount payment for non-medically necessary services which could ultimately jeopardize their financial and operational integrity and ability to provide discount payment and charity care for medically necessary services for uninsured and underinsured individuals. Additionally, requiring hospitals to obtain an attestation from a patient's referring provider or treating provider stating that a procedure is not medically necessary is appropriate as a medical necessity determination is within the scope of a healthcare provider's regular job duties. Further, a patient's referring provider or treating provider is the most appropriate person to make a medical necessity determination as they have personal knowledge of the patient's medical condition and history.

This provision applies only to discount payment and not to charity care policies. The Act clearly states the minimum criteria for discount payment eligibility, although hospitals are permitted to be more generous with their discount payment program. However, it gives hospitals more discretion to determine the expected payment amount for services in their charity care policies.

---

[7] Assembly Committee on Judiciary, Analysis of Assembly Bill 1020 (2021-2022 Reg. Sess.), as amended March 30, 2021, p. 7.

[8] Assembly Committee on Health, Analysis of Assembly Bill 774 (2005-2006 Reg. Sess.), as introduced, p. 10.

Subdivision (b) clarifies what tax return and paystubs hospitals may collect from patients in order to determine eligibility for discount payment. This is necessary to ensure consistency in how eligibility is determined in the discount payment program. It is also necessary to clarify that the documentation should be recent to the date the patient was billed, as patients could be applying at various times after the service. In determining the maximum number of paystubs the hospitals can collect, the Department reviewed existing hospital policies. While many existing policies are silent, no hospital policy reviewed by the Department requested more than six months of paystubs. As such, the Department believes this is enough paystubs for the hospital to collect to document patient income, while still not requiring an entire year's worth of paystubs to document income which would be more burdensome on patients.

Subdivision (c) clarifies the start date for the 90-day period outlined in HSC section 127425 (i). This is necessary to ensure that patients receive a full 90 days after a missed payment before the payment plan is declared inoperative.

Subdivision (d) specifies the time period in which hospitals must send notices. This is necessary to ensure that the patient receives notice required by HSC section 127425 (i) close in time to when the payment plan is at risk of being declared inoperative, so the notice is seen as pertinent to the patient, but still with sufficient time for the patient to rectify the missed payment or renegotiate their payment plan before it is declared inoperative.

Subdivision (e) specifies that once a payment plan is declared inoperative, the patient shall still be responsible for the discounted payment amount previously determined, minus any payments already made. This is necessary to uphold the intent of the discount payment program, which is to reduce or eliminate medical debt. In the case that a patient falls behind on discount payments, this will ensure patients are treated fairly by hospitals and receive credit for payments made prior to the payment plan being declared inoperative.

§ 96051.8. Applications for Eligibility for Discount Payment or Charity Care

Hospitals must have applications for patients to apply for charity care and discount payment. The documentation of income that hospitals can request under the discount payment program is limited to paystubs and tax returns. However, hospitals may request additional asset information for charity care. In this section, the Department seeks to clarify the application such that patients are informed that they may apply for discount payment without applying for charity care if they do not want to provide additional asset information. The benefit of this is to encourage more patients to apply for the program and not be dissuaded by the requirement to provide large amounts of documentation.

Subdivision (a)(1) explains that hospitals with a single application form for both charity care and discount payment program shall specify on their application form that if a patient is only applying for discount payment, the hospital may only request the

documentation of income allowed by HSC section 127405 (e)(1). This is necessary to ensure patients unwilling to submit information about their monetary assets may still have access to the discount payment program.

Subdivision (a)(2) specifies that hospitals with a single application form for both charity care and discount payment shall specify on their application form that patients who only apply for discount payment may receive less financial assistance than if they applied for charity care. This is necessary to ensure patients are notified that if they do not provide all the requested financial information, they may be eligible for less financial assistance.

Article 3. Notice and Posting Requirements

§ 96051.9. Discharge Notice

The purpose of this section is to specify the requirements of the discharge notice, so patients have information on the availability of hospital discount payment and charity care, the Hospital Bill Complaint Program, and Health Consumer Alliance. The specific requirements of the discharge notice are outlined below.

Subdivision (a) explains that the requirements for written discharge notices under HSC sections 127410 (a) through (b) shall comply with specific requirements listed in the proposed regulation. Related subdivisions (a)(1) through (a)(3)(G) outline the specific requirements and are discussed below.

Subdivision (a)(1) states hospitals must provide discharge notices in hardcopy format. A hardcopy format is necessary to increase the likelihood that patients receive the discharge notice and can read and revisit its content.

Subdivision (a)(2) states hospital discharge notices must comply with the accessibility standards listed in section 96051.1. This is necessary to prevent discrimination and ensure all patients can access the information provided in the notice.

Subdivision (a)(3) states discharge notices must include specific content listed in related subdivisions (a)(3)(A) through (a)(3)(G), below.

Subdivision (a)(3)(A) states the discharge notice must include information on the availability of discount payment and charity care, and instructions on how the patient may apply. This is necessary to give patients notice about the availability of discount payment and charity care and inform them of how they may apply for financial assistance.

Subdivision (a)(3)(B) states the discharge notice must include information on where the patient may access the hospital's discount payment and charity care policies. This is necessary so the patient knows how to access discount payment and charity care policies. Discount payment and charity care policies contain a lot of important information about financial assistance including details about the available financial assistance programs, definitions, eligibility information, and information regarding the hospital eligibility determination processes.

Subdivision (a)(3)(C) states the discharge notice must include eligibility information. This is necessary so patients may assess whether they are eligible for discount payment or charity care and decide whether they would like to apply.

Subdivision (a)(3)(D) states the discharge notice must include contact information for a hospital employee or office where the patient may obtain more information about discount payment and charity care. This is necessary so the patient knows where they may go for more information. A patient may not, for instance, have a computer or internet connection handy, or may not feel comfortable unless they talk to a specifically designated person about their situation.

Subdivision (a)(3)(E) states the discharge notice must include the internet website for the hospital's list of shoppable services. This is required by statute in HSC section 127410. Reiterating this statutory requirement in the regulation is necessary for clarity because it consolidates each of the requirements together within the regulation.

Subdivision (a)(3)(F) states the discharge notice must include the statement on the Hospital Bill Complaint Program outlined section 96051.3. This is necessary so the patient knows about the Hospital Bill Complaint Program in the event that their application is later denied and they would like to file a complaint about the hospital's determination. The specific language from section 96051.3 is required so patients receive complete and consistent information about the Hospital Bill Complaint Program.

Subdivision (a)(3)(G) states the discharge notice must include information on Health Consumer Alliance, including a specific statement that is included in this subdivision. This is necessary so the patient knows they have the option to obtain additional assistance. The regulation includes a specific statement so hospitals provide complete and consistent information about Health Consumer Alliance.

Subdivision (b) explains hospitals shall maintain proof that the written discharge notice was provided to patients in accordance with hospital record retention requirements as outlined in applicable state and federal law. The purpose of this subdivision is so hospitals will have a record regarding whether they complied with the Act's requirement to provide each patient with a written discharge notice. This is necessary in the event of an enforcement action from the Department, as the hospital will need to be able to document whether they complied with the written discharge notice requirement. Rather than burden the hospital by dictating what the proof should be, the Department is leaving it up to each hospital to determine what the best method will be in accordance with their other procedures and processes.

§ 96051.10. Hospital Postings

The purpose of this section is to clarify the requirements for hospital postings on discount payment and charity care. This section refers to hospital postings, which must be posted on the wall in certain public areas of a hospital to provide patients with notice about discount payment, charity care, the Hospital Bill Complaint Program, and Health

Consumer Alliance. This section clarifies the requirements for hospital postings in regard to format and content.

Subdivision (a) states hospital postings must comply with specific requirements listed in the following related subdivisions.

Subdivision (a)(1) states hospital postings have minimum font size requirements, which are further clarified in related subdivisions (a)(1)(A) through (a)(1)(C).

Subdivision (a)(1)(A) states the minimum main title font size is 72-point. Subdivision (a)(1)(B) states the minimum section heading font size is 42-point. Subdivision (a)(1)(C) states the minimum body text heading font size is 24-point. Resources on accessible text for printed posters state the specific required text sizes are the minimum font sizes that may be considered accessible for printed posters.[9] Font sizes on printed posters should be legible from a distance of three to six feet for individuals, including those with low vision.[10] These minimum font sizes are necessary to avoid discrimination.[11]

Subdivision (a)(2) states hospital postings shall use a white background and black text. A white background and black text is recommended by the Department of Rehabilitation for accessibility so the background and text have sufficient contrast, which allows the widest number of patients to be able to read the posting's content.[12]

Subdivision (a)(3) states hospital postings shall be printed on paper that is no smaller than 11" x 17". This minimum page size is necessary to accommodate the required hospital posting content pursuant to section 96051.10 (b) at the required font sizes pursuant to sections 96051.10 (a)(1)(A) through (a)(1)(C).

Subdivision (a)(4) states hospital postings shall be designed and presented in a way that is easy for the patient to read and understand. This is necessary to ensure the hospital posting is able to be read by the greatest number of patients.

Subdivision (a)(5) states the hospital posting should use plain, straightforward language that avoids technical jargon. This is necessary so the content is written in a way that is understandable by the greatest number of patients. Plain language requirements are

---

[9] Yale Academic Poster Resources: Accessibility, https://guides.library.yale.edu/academic-poster-resources/accessibility; Guidelines for Creating Accessible Printed Posters, p. 3, https://www.aucd.org/docs/annual_mtg_2008/accessibility_posters_gilson2007.pdf .

[10] Guidelines for Creating Accessible Printed Posters, p. 3, https://www.aucd.org/docs/annual_mtg_2008/accessibility_posters_gilson2007.pdf .

[11] *Id*.

[12] DOR Accessibility Standards 1.0, p. 4, https://publicaccessstorage.blob.core.usgovcloudapi.net/publicsitefiles/DOR%20Documents/Disability%20Access%20Services/DOR%20Document%20Accessibility%20Standards%20June%202019.pdf

also specified by the Federal Plain Writing Act of 2010, Public Law 111-274, and California Government Code section 6219 (a)(b).

Subdivision (a)(6) states that hospital postings shall meet the language requirements outlined in HSC section 127410. This is necessary to prevent discrimination and help provide patients with access to the posting's content in a language that the patient reads and understands, as required by existing state and federal law.

Subdivision (b) lists what content is required in hospital postings, which is specified in the related subdivisions, below.

Subdivision (b)(1) states the hospital posting shall have a main title called "Help Paying Your Bill" that is followed by information about the availability of discount payment and charity care. The purpose of this subdivision is to ensure the hospital posting includes information about discount payment and charity care. This clarification is necessary because otherwise HSC section 127410 does not specify what information the hospital posting must include. Including information on the availability of discount payment and charity care is necessary so patients have notice about available hospital financial assistance programs.

Subdivision (b)(2) states the hospital posting shall have a title called "How to Apply" that is followed by the contact information for a hospital employee or office where the patient may obtain information about discount payment and charity care policies and how a patient may apply. This is necessary so patients know where they may go to get additional information about discount payment and charity care.

Subdivision (b)(3) states the hospital posting shall have a title called "Hospital Bill Complaint Program" that is followed by template language about the Hospital Bill Complaint Program. This is necessary so patients know they may file a complaint with the Hospital Bill Complaint Program if they feel they were improperly denied discount payment or charity care. Using the specific template language ensures patients are provided with complete and consistent information regarding the Hospital Bill Complaint Program.

Subdivision (b)(4) states the hospital posting shall have a title called "More Help" that is followed by information that there are organizations that will help the patient understand the billing and payment process. The Health Consumer Alliance website shall also be included. This is necessary so patients know Health Consumer Alliance is available to provide additional assistance. The Health Consumer Alliance website ensures patients know how to get in contact with Health Consumer Alliance.

Subdivision (b)(5) states the hospital posting shall include information about how a patient with a disability may access the posting content in an alternative format. This is necessary to prevent discrimination and promote equity of access.

Subdivision (b)(6) states the hospital posting shall include information on how a patient may access the hospital posting in another language. This is necessary so limited

English proficient patients, their families, and advocates can see that they may be able to obtain the hospital posting in another language. Additional languages are required by HSC section 127410, as determined by California Insurance Code section 12693.30.

Subdivision (c) states Department staff shall be permitted to enter the hospital during business hours, Monday through Friday, 9 a.m. to 5 p.m., to inspect hospital postings. This time is provided as a reasonable exception of hours with hospital staff available to answer questions and should not come as a burden to hospitals. In subdivisions (c)(1) through (c)(4), the proposed regulation specifies that Department staff may enter areas that are visible to the public including, but not limited to, the emergency department, billing office, admissions office, and other outpatient settings. The purpose of this subdivision is to clarify when Department staff may enter the hospital to perform their inspection. This is necessary to ensure Department staff will be able to perform their inspection to ensure compliance under HSC section 127410 (c).

Subdivision (d) states Department staff may, but are not required to, inform the hospital of their findings at the time of the inspection. The purpose of this section is to clarify that upon the completion of their inspection, Department staff can, but are not required to, notify the hospital of its findings. This is necessary because while hospital staff will ideally be present and able to sign off on the Department's findings, if hospital staff are not available to sign and acknowledge the results of the inspection, Department staff may still conclude the inspection.

§ 96051.11. Website Requirements

This section is necessary to clarify the hospital website requirements for the Hospital Bill Complaint Program. HSC section 127410 (c)(5) states hospitals must include a webpage with their discount payment and charity care policies. This section further clarifies specific hospital website requirements.

Subdivision (a) states hospital internet websites pursuant to HSC section 127410 (c)(5) shall comply with specific requirements listed under the related subdivisions (a)(1) through (a)(5).

Subdivision (a)(1) explains hospitals shall maintain an internet webpage titled "Help Paying Your Bill," which includes specific information stated in the related subdivisions (a)(1)(A) through (a)(1)(D).

Subdivision (a)(1)(A) states the "Help Paying Your Bill" webpage shall include information on the hospital's eligibility requirements for discount payment and charity care. A distinct webpage that is exclusively dedicated to financial assistance content will allow patients to conveniently access all discount payment and charity care information from the same webpage. This is necessary so patients can easily obtain eligibility information and assess whether they qualify for financial assistance without having to filter through unrelated content or visit numerous webpages.

Subdivision (a)(1)(B) states the “Help Paying Your Bill” webpage shall include instructions on how to apply for discount payment and charity care. This is necessary so patients have information on how they can apply for discount payment or charity care.

Subdivision (a)(1)(C) states the “Help Paying Your Bill” webpage shall include a link to the discount payment and charity care policies and application(s). This specifically implements HSC’s requirements to “link to the policy itself” while clarifying the “policy.” Linking to the application(s) is necessary so patients are able to access the application and apply. Because the population served by the Act includes populations that regularly face many barriers, having the application as accessible as possible helps reduce one of the hurdles patients may face in applying for discount payment or charity care.

Subdivision (a)(1)(D) states the “Help Paying Your Bill” webpage shall include information on the office where a patient may go for more information about discount payment and charity care. This is necessary so patients know where they may go for more information if they have additional questions that are not answered on the hospital’s “Help Paying Your Bill” webpage, which implements the intent of AB 1020.

Subdivision (a)(2) states the “Help Paying Your Bill” webpage shall be accessible through links that are prominently displayed on the hospital’s website. Use of the term “prominently displayed” repeats the statutory requirement, which is further clarified in this regulation. The related subdivisions, discussed below, specify the specific locations the hospital website must display the “Help Paying Your Bill” webpage link. This is necessary so the links to the “Help Paying Your Bill” webpage are visible to the average webpage user. It can be difficult for people to navigate websites, and computer literacy varies among users. Unless the website link is prominently displayed, patients may be unable to locate the link that will lead them to information about the hospital’s discount payment and charity care programs, as well as the Hospital Bill Complaint Program. These clarifications are so patients using hospital websites will be able to easily find the “Help Paying Your Bill” webpage.

Subdivision (a)(2)(A) states the “Help Paying Your Bill” webpage link must appear in the hospital website’s footer. This is necessary because the footer appears on every webpage throughout the hospital’s website and is one consistent place where the “Help Paying Your Bill” webpage link can appear for patients. Website footers typically contain important general links, which is the case for the “Help Paying Your Bill” webpage.

Subdivision (a)(2)(B) states the “Help Paying Your Bill” webpage link must appear on any webpage where the patient may find information about paying a bill. This is necessary because if a website user is looking at information about paying their bill on the hospital website, they likely have a hospital bill and therefore benefit from knowing financial assistance may be available to them. This clarification seeks to ensure relevant information on financial assistance is provided to patients.

Subdivision (a)(2)(C) states the “Help Paying Your Bill” webpage link must appear in the hospital website’s header or within one click on the hospital’s drop-down menu from the

hospital website's header. This is also necessary to ensure general website users will see the option to visit the "Help Paying Your Bill" webpage when navigating the website's drop-down menu.

Subdivision (a)(3) states the "Help Paying Your Bill" webpage link shall be consistent with other text sizing, or larger, within the hospital website's header and footer. Additionally, if the link appears elsewhere on the hospital's website, such as on a webpage where the patient may find information about paying a bill, the "Help Paying Your Bill" link shall be in at least 12-point size sans serif font and distinguished from other text on the webpage (bolded/underlined). This is necessary so the links are visible for the average website user and comply with the aforementioned accessibility guidelines.

Subdivision (a)(4) states all "Help Paying Your Bill" links shall be reasonably designed to be noticeable to average patients using the hospital's website. Again, this is necessary to provide access to patients, while realizing that there is a reasonable or average patient standard.

Subdivision (a)(5) states the "Help Paying Your Bill" webpage must have information on the Hospital Bill Complaint Program, including the specific prescriptive language provided in this subdivision. This is necessary so messaging about the Hospital Bill Complaint Program is complete and consistent for all patients.

Article 4. Hospital Bill Complaint Program

§ 96051.12. Hospital Designated Contact and Statement of Certification

The purpose of this section is to specify requirements for hospitals to provide a designated contact who will respond to complaints on behalf of the hospital, correspond with the Department during the complaint review process, and certify that all responses and information submitted to the Department by the hospital are true and correct to the designated contact's knowledge.

Subdivision (a) specifies that each hospital must designate an individual who must register with the Department's online patient complaint portal to review and respond to patient complaints. This provision is necessary to ensure the Department has a designated individual to contact regarding requested information and responses. The Department acknowledges that requiring hospitals to utilize its online patient complaint portal, described in section 95601.13, is a prescriptive standard. The Department has determined that a performance standard would not be appropriate or feasible. All patient complaints will be reviewed by the Department through the online patient complaint portal, including patient complaints received by mail, which will be manually uploaded to the online patient complaint portal by the Department. The Department will request hospital responses through the online patient complaint portal. Mailing details of a patient complaint and requesting the hospital's response would be difficult, burdensome, and inefficient for the Department. Mailing responses, included printed

copies of requested documents, would impose additional costs on hospitals in order to respond. Further, patient complaints and hospital responses will include confidential protected health information. The Department's online patient complaint portal will provide safeguards to protect confidential patient information. By utilizing the online patient complaint portal, the Department can more efficiently and effectively utilize its limited resources while also safeguarding sensitive protected health information related to patient complaints.

Subdivisions (b)(1) through (b)(6) specify the information a hospital's designated contact must provide to the Department when registering in the Department's online patient complaint portal. These provisions are necessary to clarify what information is required so the Department knows who the hospital's designated contact is and how to contact them outside of the online patient complaint portal as needed. Listing the legal name of the hospital ensures that the contact is matched appropriately. The name, business title, and email address of the contact are necessary for communications. The business address and phone number of the contact are necessary because the primary contact may not be at the hospital itself but may work in an auxiliary location.

Subdivision (c) specifies the deadline to update any changes to the information outlined in subdivisions (b)(1) through (b)(6). This provision is necessary to ensure that the Department can contact a designated individual for the hospital if any of the information listed in subdivisions (b)(1) through (b)(6) changes. In the Department's experience, 10-working days is considered a reasonable time within which to notify the Department of such a change.

Subdivision (d) specifies that a hospital's designated contact may add approved users to respond on behalf of the hospital in the Department's online patient complaint portal. This provision is necessary to allow hospitals to make decisions on the number of personnel needed to respond to complaints and allow hospitals to have control over internal personnel decisions such as delegating duties to specific employees.

Subdivision (e) specifies that each hospital subject to the Act shall register with the Department's online patient complaint portal by January 1, 2024, and that any facilities that become licensed in the future under HSC section 1250 (a), (b), or (f) shall register prior to treating patients. This provision ensures that currently licensed hospitals subject to the Act will be able to respond to any patient complaints or correspondence from the Department when the Department's enforcement jurisdiction begins on January 1, 2024. This also ensures that facilities that become licensed in the future and would be subject to the Act will be able to respond to any correspondence or complaints from the Department as soon as the facility begins treating patients.

Subdivisions (f)(1) through (f)(2) specify that a designated contact or authorized user from a hospital who submits responses through the Department's online patient complaint portal shall electronically sign a statement of certification under penalty of perjury, certifying that the submitter is an official of the hospital who is authorized to

submit the response and that the submitted response is true and correct. These provisions are necessary to ensure that submitters are submitting responses that are true and correct to their knowledge and are not knowingly submitting false or misleading responses. Certification under penalty of perjury helps to ensure that the documentation contains truthful, factual representations made in good faith. (See, e.g., *In re Marriage of Reese & Guy* (1999) 73 Cal.App.4th 1214, 1223 [judicial explanation for the use of certifications under penalty of perjury: "The whole point of permitting a declaration under penalty of perjury, in lieu of a sworn statement, is to help ensure that declarations contain a truthful factual representation and are made in good faith."]) In addition, such certification helps ensure the reliability of the statements to the Department, since the act of certifying under penalty of perjury can have a deterrent effect on those who may be considering not providing true, accurate, or complete information.

§ 96051.13. Patient Complaint Portal

The purpose of this section is to specify how patients may file a complaint with the Department. This provision explains that complaints may be filed online through the Department's online patient complaint portal or by mail to the Department's Legal Office. This provision is necessary to clarify how and where a complaint may be made to the Department. This provision also provides patients with multiple options for how to file a complaint. For patients who may not have access to a computer or the internet to file a complaint online, there is an option to mail in a complaint to the Department. This will benefit patients without computer or internet access who may be unable to file a complaint online.

§ 96051.14. Authorized Representative

The purpose of this section is to specify an authorized representative may file a complaint on behalf of a patient if they are designated either by the patient or by law to act on behalf of the patient in the complaint process. This section states what information the patient or authorized representative must submit to the Department in order to be recognized by the Department as the patient's authorized representative, and how a patient or authorized representative may modify or cancel the authorization at any time.

Subdivisions (a)(1) through (a)(3) define "authorized representative" as an individual who may act on behalf of a patient in submitting a complaint to the Department and explain the three different categories of authorized representative designations. These provisions are necessary to ensure patients who want or need assistance in filing a complaint can utilize someone to act on their behalf. These generally recognized legal provisions are detailed here because patients may be unaware that they can authorize someone else to assist them with the Department's complaint process. Patients designating an authorized representative pursuant to section 96051.14 (a)(1) may designate any individual to act as their authorized representative, including but not limited to a spouse, relative, friend, attorney, social worker, or community advocate.

Authorized representatives designated by law pursuant to section 96051.14 (a)(2) may include, but are not limited to, individuals with power of attorney authorization, trustees, and court ordered conservators.

Subdivision (b) explains that an authorized representative may file a complaint and act on behalf of the patient in the Department's complaint process. Additionally, a parent, guardian, or conservator of a minor patient is not required to submit the information required under subdivision (c) because California law authorizes parents and legal guardians of minor children to give consent for most medical decisions on behalf of the minor. This provision is necessary to clarify the authority granted to an authorized representative to act on behalf of a patient in the Department's complaint process and to clarify what is required from parents, guardians, or conservators of minor patients. This provision benefits patients who may wish to have assistance in filing a complaint with the Department along with patients who require an authorized representative to act on their behalf due to incompetence or incapacity.

Subdivisions (c)(1) through (c)(6) specify the information the patient or authorized representative must submit to the Department, including identity of the patient and authorized representative, relationship between the patient and authorized representative, and contact information of the authorized representative. These provisions are necessary to ensure the Department has the necessary information to identify and contact the authorized representative about the complaint.

Subdivision (c)(7) specifies that a patient's signature is required if the patient is appointing an authorized representative in writing pursuant to 96051.14 (a)(1). This provision is necessary to document and verify that the patient is voluntarily appointing an authorized representative to assist in the complaint process and that the Department is authorized to share confidential information with the authorized representative.

Subdivision (c)(8)(A) requires documentation of legal authority to act as the patient's authorized representative, if applicable, pursuant to 96051.14 (a)(2). This provision is necessary so the Department can verify that the authorized representative has legal authority to act on behalf of a patient, if applicable.

Subdivision (c)(8)(B) specifies that an authorized representative's signature is required if the authorized representative is designated by law to act on behalf of the patient pursuant to 96051.14 (b). This provision is necessary as the authorized representative stands in the place of the patient and a signature is required for the Department to obtain information necessary to investigate the complaint.

Subdivisions (d)(1) through (d)(4) specify under what circumstances an authorization for an individual to act as an authorized representative may be modified or canceled: A patient may decide they no longer want assistance with the Department's complaint process, an authorized representative may decide they no longer want to assist a patient with the Department's complaint process, an authorized assistant designated by law may lose the legal authority to represent the patient if circumstances change, or an

authorization shall conclude when the patient complaint is closed. These provisions are necessary to ensure that a patient or an authorized representative may modify or cancel an authorized representative designation, and the Department may modify or cancel an authorized representative designation if the Department becomes aware that the authorized representative's legal authority has been modified or terminated. Further, an authorization shall end when a patient complaint is closed. In this way, confidential or sensitive information sharing will no longer occur after the authorization concludes, which protects the patient.

§ 96051.15. Release of Information

This section specifies that a patient or authorized representative shall sign a release of information which will authorize the Department to request all information necessary, from the applicable hospital, for the Department to investigate the patient's complaint. It also specifies that a signed release of information is required for each complaint and will be valid until revoked by the patient or authorized representative. This provision is necessary to ensure that patients are aware of the type of information the Department may be requesting and reviewing, and it ensures that the Department is authorized to review all information that is necessary to make a determination, including information that may be sensitive or confidential. Further, such access to information is also limited to the narrow confines of the investigation, and so will end once the investigation concludes, for security of patient confidentiality.

§ 96051.16. Filing a Patient Complaint

This section lists the information necessary for the Department to investigate a patient complaint regarding financial assistance. This includes the patient's identifying information, contact information, demographic information, specific information about the complaint being filed, and patient or authorized representative signatures authorizing release of information pursuant to proposed section 96051.15, designation of an authorized representative pursuant to proposed section 96051.14, if applicable, and acknowledgment of receipt of a notice of rights pursuant to the Information Practices Act of 1977.

Subdivision (a) states that complaints may be made to the Department electronically or in writing signed by the patient or their authorized representative. Additionally, the Department will make the information required by subsection (b) available through the online patient complaint portal or by mail upon the patient's request. This provision is necessary to provide the option for patients and authorized representatives to submit a complaint electronically or in writing by mail. This provides access to the complaint process for all individuals, including those without computer or internet access who may be unable to file a complaint online.

Subdivisions (b)(1) through (b)(4) specify the identifying information required by the Department, including the patient's name, name of parent/guardian if the patient is a

minor, date of birth, and sex. These provisions are necessary for the Department to be able to identify the patient and match hospital records to the correct patient complaint.

Subdivision (b)(5) requires the patient to state their family size as defined in HSC section 127400 (h). This provision is necessary for the Department to review the patient's eligibility for discount payment and/or charity care, as family size is tied to eligibility in the Act.

Subdivisions (b)(6) through (b)(9) specify the contact information required by the Department, including the patient's mailing address, primary phone number, secondary phone number, if available, and email address, if available. These provisions are necessary for the Department to be able to contact the patient regarding the complaint.

Subdivision (b)(10) requires the patient to state whether they need an interpreter and, if so, what their preferred language is. This provision is necessary so the Department can contact the patient, if necessary, by telephone or in writing in the patient's requested language.

Subdivisions (b)(11) through (b)(12) require the patient to identify the name and address of the hospital involved in the patient's complaint along with the date(s) of service(s) being billed by the hospital. These provisions are necessary for the Department to identify the correct hospital to contact regarding the complaint and to identify the service(s) and bill(s) related to the patient's complaint.

Subdivisions (b)(13) through (b)(15) require the patient to provide information on health plan or insurance coverage and membership number(s) at the time of service(s), information on what health plan or insurance providers processed and paid claims for the service(s) at issue, and the date the patient filed grievance(s) with the health plan about any denial(s), including any information about the health plan's response. These provisions are necessary for the Department to review the complaint for eligibility for discount payment and/or charity care.

Subdivision (b)(16) requires the patient to provide information on the date of injury if their service(s) results from injury caused by a third party. This provision is necessary for the Department to review the complaint for eligibility for discount payment and/or charity care.

Subdivisions (b)(17) through (b)(19) require the patient to provide information on any Medi-Cal, Medicare, or other government health program coverage, if applicable. These provisions are necessary for the Department to review the complaint for eligibility for discount payment and/or charity care.

Subdivisions (b)(20) through (b)(21) require the patient to provide the date they submitted a financial assistance application to the hospital and whether it was approved or denied, if applicable, as well as the date of any appeal of the hospital's determination. These provisions are necessary for the Department to review the complaint for hospital compliance with the Act and proposed regulations.

Subdivisions (b)(22) through (b)(23) require the patient to submit copies of hospital notice(s) and billing statement(s) received, if applicable, and copies of proof of payment for any amount(s) paid by the patient to the hospital for the service(s) at issues, if applicable. These provisions are necessary for the Department to review the complaint for hospital compliance with the Act and proposed regulations.

Subdivisions (b)(24) through (b)(25) require the patient to provide information on the date the hospital sold the patient's debt to collections or the date the patient was notified the bill was in jeopardy of being sent to collections, if applicable, as well as documentation that the debt was reported to a credit bureau and the patient's credit report/score was impacted, if applicable. These provisions are necessary for the Department to review the complaint for hospital compliance with the Act and proposed regulations.

Subdivision (b)(26) requires a patient or authorized representative signature authorizing a release of information pursuant to proposed section 96051.15. This provision is necessary for the Department to be able to request and receive all relevant and necessary information related to the patient's complaint in order to review the complaint.

Subdivision (b)(27) requires a patient or authorized representative signature in order to designate an authorized representative pursuant to proposed section 96051.14. This provision is necessary for the Department to document that a patient has designated an authorized representative or to establish that an authorized representative has been designated by law to act on behalf of a patient.

Subdivision (b)(28) requires a signed acknowledgement that the Department provided the patient and/or authorized representative with a notice of rights pursuant to the Information Practices Act of 1977. This provision is necessary for the Department to document that the patient or authorized representative received notice of the requirements, prohibitions, and remedies applicable to the Department about its collection, storage, and disclosure of the patient's personal information, which is necessary by law under California Civil Code section 1798.17.

Subdivision (b)(29) requires a signature from the patient or authorized representative, if applicable, in order to submit a complete complaint. This provision is necessary to certify that the patient or authorized representative is the individual submitting the complaint to the Department.

§ 96051.17. Complaint Review

In order to investigate patient complaints, the Department must have a review process in place. This subdivision outlines the Department's complaint review process, including when a complaint can be considered by the Department, what steps the Department will take upon receipt of a complaint, the requirements and deadlines for hospitals and patients to respond to the Department regarding the complaint, and the requirements

and remedies for hospitals and patients after the Department's preliminary and/or final determination is made.

Subdivision (a) specifies that the Department will not consider a complaint unless the patient has already submitted an application for discount payment and/or charity care to the hospital for the services at issue in the complaint. This provision is necessary because a hospital must have the opportunity to make a determination about the patient's eligibility for discount payment and/or charity care prior to the Department reviewing whether the hospital complied with the Act and the proposed regulations.

Subdivision (b) specifies that upon receipt of a complaint, the Department will forward the complaint to the hospital for response. Although not a duty or obligation on a patient or hospital, this informational provision is necessary to clarify what action the Department will take in response to receiving a complaint.

Subdivision (b)(1) specifies that a hospital shall respond to a complaint within 10 working days. This provision is necessary to give hospitals time to investigate the complaint and collect and submit the necessary information to respond to the complaint. Working days was chosen here instead of calendar days because the Department understands that the administrative staff may not work the same 24/7 as the other staff in the hospital. Further, because of schedule rotation, it may take a few days to reach persons with knowledge of the patient's treatment plan. The Department has an interest in promptly resolving patient complaints, as the complaints may involve issues which negatively affect patients financially. However, hospitals may request extensions pursuant to section 96051.18.

Subdivision (c)(1) specifies that a hospital response to the Department shall include a detailed explanation of the hospital's position on the patient's eligibility for financial assistance. This provision is necessary so the Department receives a detailed justification of the hospital's position regarding the patient's financial assistance eligibility determination in order to assist the Department in making a compliance determination.

Subdivision (c)(2) specifies the documents a hospital must provide to the Department with their response, including copies of all documents and information relevant to the issues raised in the complaint. This provision is necessary to ensure the Department has the records needed to investigate the complaint and determine whether a violation occurred.

Subdivision (d) explains that the Department may request additional information or records from the patient and the hospital at any time during the review process. This provision is necessary to explain the Department may identify additional information or records that are necessary for the Department to complete its investigation.

Subdivision (d)(1) specifies that the additional information or records referred to in subdivision (d) must be provided to the Department within 10 working days, unless

extended pursuant to section 96051.18. As described above, this provision is necessary to give hospitals and patients time to collect and submit the requested information. The Department also has an interest in promptly resolving patient complaints, as the complaints may involve issues which negatively affect patients financially.

Subdivision (e) explains that the Department will make a compliance determination upon receipt of all available and relevant information based on the criteria outlined in the Act and associated regulations. This provision is necessary to clarify that the Department will not make a compliance determination until all necessary information has been provided and the standards the Department will use in determining compliance.

Subdivision (f) explains that if the Department finds the hospital out of compliance, the Department will issue a preliminary out of compliance notice to a hospital detailing the hospital's alleged violation(s). This informational provision is necessary to clarify what action the Department will take after a making a preliminary out of compliance determination so that all parties know what to expect.

Subdivision (f)(1) specifies that a hospital shall have 30 calendar days after the preliminary out of compliance notice is issued to respond to the Department's initial determination. This provision is necessary to give the hospital time to review the Department's initial determination and decide whether to accept or contest the determination. This provision provides 30 days, longer than the 10-day periods mentioned above, so that the hospital has adequate time to prepare and submit a response to the Department if it decides to contest the determination. The Department also has an interest in promptly resolving patient complaints, as the complaints may involve issues which negatively affect patients financially. In the Department's experience, more than 30 days would be unnecessary for a hospital's review and response time.

Subdivision (f)(2) specifies that if a hospital responds to the Department's preliminary out of compliance determination and the Department does not change its determination, or if a hospital does not respond within 30 calendar days to the Department's preliminary out of compliance notice, a letter will be sent to the patient and the hospital stating the hospital is out of compliance with the Act and/or the corresponding regulations and an administrative penalty is being assessed. This provision is necessary to clarify what action the Department will take if the hospital either does not contest the initial determination or if the initial determination is upheld after the Department reviews the hospital's response. This provides a certainty of consequence.

Subdivisions (g)(1) through (g)(3) specify that if a hospital does not file an appeal within 30 calendar days from the date the Department's final determination notice was issued, the hospital shall reimburse the patient any amount owed, plus interest, pursuant to HSC section 127440, and provide the Department with proof of reimbursement within 30 calendar days from the date the final determination notice is issued, if applicable.

The hospital shall also pay all assessed penalties to the Department within 30 calendar days from the date the deadline to appeal has passed, if applicable. These provisions are necessary to clarify what hospitals are required to do and the deadline to complete these requirements if no appeal of the Department's final determination is filed. As above, 30 calendar days was determined to be a reasonable time to respond by appealing a determination or reimbursing a patient and notifying the Department. Unlike the 10-day response times for providing existing information, deciding whether to file an appeal may involve a hospital's legal office or outside counsel, and reimbursements may involve a separate accounting firm. Further, in the Department's experience, 30 calendar days after the deadline to appeal has passed is a reasonable deadline for hospitals to pay assessed penalties to the Department.

Subdivisions (h)(1) through (h)(3) specify that if a hospital files an appeal of the Department's final determination, and the final determination is upheld on appeal, the hospital shall reimburse the patient any amount owed, plus interest, pursuant to HSC section 127440, provide the Department with proof of reimbursement, and pay all assessed penalties to the Department within 30 calendar days from the date of the Director's written final decision, pursuant to section 96051.37, if applicable. These provisions are necessary to clarify what hospitals are required to do within 30 calendar days from when the Director either rejects or adopts the administrative hearing officer's decision in the hospital's appeal. Thirty calendar days is consistent with the above assessments.

§ 96051.18. Request for Extension

The Department understands that upon receipt of a complaint or request from the Department, there may be circumstances when a hospital may need additional time to gather the requested information and respond to comments. This section outlines the process and standard of review for extension requests.

Subdivision (a) specifies that a hospital may request an extension if it cannot provide a response to a request for information from the Department within the required 10 working days. This provision is necessary to allow hospitals that may need more time to collect and provide the necessary information to still be in compliance if they request an extension and it is approved by the Department.

Subdivision (b) specifies that the Department may grant an extension request depending on a number of listed factors. This is necessary to provide a basis for the Department's determination and to advise the hospital of what they may need to prove to obtain an extension.

Subdivision (b)(1) indicates the Department will consider complexity of the required response from the hospital. This is necessary to take into account how much time the hospital will need for the required response and allow the Department to grant extra time if it is a complex response that will require additional time.

Subdivision (b)(2) indicates the Department will consider a hospital's history of cooperativeness. This is necessary to account for whether the hospital generally is responsive to the Department or whether the hospital is chronically difficult to work with- and may reflect credibility of the hospital's request.

Subdivision (b)(3) indicates the Department will consider necessity for a third party to assist the hospital in obtaining records. This is necessary to account for additional time the hospitals may need to obtain the needed records due to external factors not under their control.

Subdivision (b)(4) indicates the Department will consider any other factors submitted by the hospital showing good cause. This is necessary to allow for other factors that the hospital may raise in support of their extension request.

Subdivision (c) indicates that no penalty will apply if an extension is granted pursuant to proposed subdivision (b). This is necessary to encourage hospitals to request an extension when they cannot meet the deadline for responding to the Department. By requesting the extension, the Department is on notice that the requested documents may be delayed rather than have the Department devote resources to checking on status or initiating penalty proceedings.

§ 96051.19. Debt Collection Ceased While Complaint Pending

This section specifies that a hospital shall not submit a patient to collections and all collections activity shall cease while a patient's complaint with the Department is pending. It further specifies that a failure to cease collection activity is grounds for a penalty under this chapter. This restriction on collections activity applies only to bills related to the patient's complaint. This provision is necessary to ensure that patients do not face negative financial consequences such as lowered credit scores for medical debt which may be reduced or be eliminated once the Department makes a determination. The penalty for failure to comply with the provision is necessary as a deterrent feature to encourage hospitals to comply with the Act.

Article 5. Administrative Penalties

The legislature placed enforcement of the Act in the hands of the Department beginning January 1, 2024.

Article 5 creates a process and penalty structure to enforce the Act and its corresponding regulations. The penalty structure contemplates violations related to hospital policies, discount payment and charity care applications, hospital postings, hospital website requirements, untimely hospital responses, untimely reimbursements to patients, and those resulting from the investigation of a patient complaint. The proposed regulations allow the Department to carry out administrative enforcement in a manner consistent with HSC section 127436 by providing a standardized approach to the assessment of administrative penalties.

§ 96051.20. Applicability

This introductory section describes the applicability of Article 5 as it pertains to the assessment of penalties for hospitals under the Act and this chapter beginning January 1, 2024, and going forward. The legislature provided authority to the Department to assume enforcement beginning January 1, 2024, under HSC section 127401.

Subdivision (a) states that Article 5, the Penalties for Violations of Fair Billing, applies only to violations by hospitals licensed by HSC section 1250 (a) (b) and (f), for violations of the Act and its corresponding regulations. This is necessary is to clarify that the article only applies to violations under the Act and this chapter.

Subdivision (b) states that Article 5 only applies to violations occurring on or after January 1, 2024. Subdivision (b) clarifies that previous violations will be subject to the regulations in effect prior to January 1, 2024, given that AB 1020 does not provide for retroactive effects. Subdivision (b) also makes clear that, although the Department does not have the authority to assess penalties for violations occurring before January 1, 2024, the Department does have the authority to consider prior violations of the Act and related federal statutes and regulations in determining the amount of penalties; this would arise, for instance, in the consideration of the criteria involving the hospital's history of cooperativeness. Subdivision (b) is necessary to clarify the timeframe for finding violations.

§ 96051.21. Penalties for Late Filing of Documents and Responses

For the Department to efficiently review hospital policies and patient complaints, the hospitals must timely submit the documents and responses required by the Act and associated regulations.

Subdivision (a) states that hospitals are subject to a penalty of $1,000 per day for a failure to timely file required discount payment, charity care, and debt collection policies and applications, and for a failure to timely respond to inquiries from the Department. This section is necessary to ensure the Department can enforce the requirement for the hospitals to submit documents on the timelines required by the Act and associated regulations. This section is also intended to deter hospitals from untimely filings.

Subdivision (b) states that a hospital is subject to a penalty of $1,000 per day for failure to submit a requested response during an investigation of a patient's complaint regarding the requirements outlined in the Act, and this chapter. HSC section 127436 gave the Department authority to develop a complaint investigation process but did not set a specific mechanism for enforcement of compliance with the investigative process. This section is necessary so the Department can enforce the requirement that hospitals respond to a complaint investigation in a timely manner. This is important to deter late responses to the Department's investigation and ensure patient complaints can be resolved in a timely manner.

For late filings of responses and documents, the Department determined $1,000 per day is appropriate as it mirrors the penalty amount in another Department program, the Drug Transparency Act. HSC section 127681 (f) requires drug manufactures to provide reports to the Department under certain circumstances. Failure to provide the report results in a $1,000 per day penalty assessment. Here, the consistent amount of $1,000 per day will encourage hospitals to timely file the required documents with the Department.

The fine calculation is based on calendar days, rather than working days, as the hospital can submit responses through the Department's portal 7 days a week. The portal will date stamp the receipt date. The Department will use the receipt date to calculate the penalty.

The Department also realizes that despite the due diligence of a hospital, there may be times when it is unable to comply with the timelines. For that reason, the Department has given hospitals a mechanism to request reasonable extensions.

§ 96051.22. Notification of Penalty Assessment for Late Filing of Documents and Responses

When the Department finds a hospital has filed documents and/or responses late, it will need to notify the hospital of the assessed penalties.

Subdivision (a) states the Department will notify the hospital's primary contact for submission of policies of an accrued penalty for the late filing of documents and/or responses pursuant to proposed section 96051.6 (b)(1), (b)(3), (b)(4), (d)(1), or (d)(4).

Subdivision (b) states the Department will notify the hospital's primary contact for complaints of an accrued penalty when documents and/or responses have been submitted late under proposed section 96051.17 (b)(1), (d)(1), or 96051.18 (a). Subdivisions (a) and (b) are necessary to outline how hospitals will be notified if penalties are assessed.

Subdivision (c) states the Department will calculate the penalty amount under subdivision (a) and (b). This section is necessary to clarify who will calculate the penalty; the hospital is not obligated to perform the calculation.

§ 96051.23. Penalty Assessment for Violations of Notice Requirements and Hospital Policies

To ensure hospitals comply with the requirement that they submit policies and applications for discount payment, charity care, and debt collection programs, in compliance with the Act and associated regulations, and provide the proper notices and postings for patients, the Department determined it must set penalties to address circumstances when a hospital fails to comply.

Subdivisions (a)(1) through (a)(3) set forth the application of this section for violations of HSC section 127435, related to the content of policies and applications for discount payment, charity care, and debt collection, as well as hospital postings and website postings required by HSC section 127410. This is necessary to identify the types of violations that are subject to the penalties outlined in this section.

Subdivision (b) sets forth the Department shall determine the penalty for each deficiency by considering the extent of noncompliance with the Act and this chapter using the factors in the subdivisions. This subdivision also notes that multiple violations will result in multiple penalties. This is subsection is necessary to clarify how penalties to system violation of policies, applications, notices and posting will be calculated. As these violations are systemic in nature, the Department determined that each violation warranted an individual penalty.

Subdivisions (b)(1) through (b)(3) set forth penalties for violations of content requirements for policies and associated applications, as well as website and posting notices. The Department is tasked in HSC section 127435 to collect and review the documents and enforcing the Act. If there are errors in the policies or applications, or errors with the notices or postings, the Department will assess penalties according to this section. The penalties range from $5,000 to $25,000, giving greatest weight to violations that will directly impact patient eligibility. Subdivisions (b)(1) through (b)(3) are necessary to provide transparency regarding the penalty structure for violations related to the content of policies and applications for discount payment, charity care, and debt collection programs, as well as hospital postings and website postings.

Subdivision (b)(4) provides the Department with the ability to close an investigation without a penalty assessment if it is determined the alleged violation does not affect patient access to, or eligibility for, the hospital's discount payment or charity care programs, so long as the hospital has taken appropriate corrective action as directed by the Department. Subdivision (b)(4) is necessary to allow the Department, when the violation is very minor, to ensure corrective action has been taken and waive an assessment of a penalty, if appropriate. This encourages prompt corrective action on behalf of the hospital, furthering the goals of the Department and the intent of the Act.

Subdivision (c) clarifies that these penalties do not apply to violations identified during the investigation of patient complaints filed pursuant to HSC section 127436.

These regulations and the associated penalties are necessary to deter future hospital violations.

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

HSC section 127436 (a) advises, "multiple violations identified during the same investigation shall constitute a single violation for purposes of assessing an administrative penalty," however "investigation" is not defined.

Subdivision (a) affirms that all violations arising out of an investigation of a patient complaint are subject to one penalty as set forth in HSC section 127436. This is necessary to provide context for the definition outlined in subdivision (b).

Subdivision (b) clarifies that an investigation is defined as information compiled from one complaint regarding one bill.

Frequently, when investigating a complaint, information will arise regarding violations related to other patients or other bills. A patient complaint may lead to information regarding violations that are systemic in nature.

Subdivision (c) indicates that violations discovered during an investigation regarding other patients or other bills are not limited to the one penalty assessment rule. This is necessary to ensure the hospital is appropriately held accountable for systemic violations. This will encourage hospitals to promptly correct systemic issues and deter further violations. Additionally, subdivisions (b) and (c) are necessary to clarify what constitutes an investigation and assess penalties in a consistent way across hospitals.

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

HSC section 127436 (b)(4) requires the Department to establish criteria to determine the amount of an administrative penalty, which must, at minimum, consider all of the following:

- The actual financial harm to patients, if any.
- The nature, scope, and severity of the violation, including whether the hospital's policies, postings, and screening practices are in compliance with HSC sections 127405 to 127435, inclusive, or whether the violation was a mistake that resulted in a violation of those policies and practices.
- The facility's history of compliance with related state and federal statutes and regulations.
- Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.
- The demonstrated willfulness of the violation.
- The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.
- The special circumstances of small and rural hospitals, as defined in HSC section 124840, if that consideration is needed to protect access to quality care in those hospitals.

In considering how to structure the assessment of administrative penalties resulting from a patient complaint, the Department considered listing the factors to weigh in determining a penalty amount with no procedure for penalty calculation or guidance as to how to weigh the criteria. However, to ensure consistency, the Department finds it

necessary to outline how the penalty will be determined, and adjusted, pursuant to the different criteria to ensure consistency in how penalties are determined.

In outlining the penalty structure, the Department considered the administrative penalty regulation set forth in title 22, CCR section 70959, which was adopted by CDPH for the assessment of penalties for violations of HSC sections 127400, *et seq*. This is the structure that is in place for violations occurring before January 1, 2024, at which time the Department will assume enforcement.

The penalty structure developed by CDPH, title 22, CCR section 70959, involves first determining a base penalty by rating the severity of the violation and then using adjustment factors to increase or decrease the base penalty. The Department utilized this overall structure but tailored the factors outlined in title 22, CCR section 70959 to include the factors added by the Act in HSC section 127436. The Department also tailored the weight of the factors to better accomplish the goals of the Act.

Notably, the base penalty was revised in the proposed regulations to give the greatest weight to the financial harm suffered by the patient as a result of an identified violation by making it the determination for the base penalty. HSC section 127346 requires the Department to consider the financial harm to the patient when determining the amount of the assessed penalty. Further, the legislative history of the Act makes clear the primary objective of the Act is to protect patients from financial harm.[13] Because the overarching goal of the Act is to protect patients from financial harm, the Department determined the financial harm should be the most heavily weighted factor, making it the basis for the base penalty.

This section outlines the first step in determining the penalty for violations resulting from an investigation of a patient complaint, which is to identify the base penalty.

Subdivision (a) explains how the base penalty for violations resulting from an investigation of a patient complaint shall be determined.

Subdivision (a)(1) provides for a base penalty of $25,000 if the violation(s) results in financial harm to the patient.

Subdivision(a)(2) provides for a base penalty of $12,500 if there is no financial harm to the patient.

Subdivision (a)(3) provides the Department the ability to close an investigation without a penalty assessment if the violation does not affect patient access to, or eligibility for, the hospital's discount payment or charity care programs and the hospital has taken corrective action as directed by the Department.

[13] Assembly Committee on Judiciary, Analysis of Assembly Bill 1020 (2021-2022 Reg. Sess.), as amended March 30, 2021, p. 1.

Subdivisions (a)(1) and (a)(2) are necessary to take patient financial harm into account in determining the penalty and ensure a penalty assessment process that is transparent to all parties. The amounts of $25,000 for financial harm, and $12,500 for no financial harm, are consistent with the amounts used in title 22, CCR section 70959.

Subdivision (a)(3) is necessary to encourage hospitals to correct minor violations and allow for no penalty assessment in those circumstances.

Subdivision (b) defines "financial harm" as a circumstance where the patient paid out-of-pocket medical costs over the adjusted discount payment or charity care amount, or the medical debt appeared on the patient's credit report. The proposed regulation also accounts for minor patients whose parent or guardian's credit report was affected. This is necessary to clarify what financial harm is for consistency in application of the base penalty.

§ 96051.26. Adjustments to the Base Penalty

This section outlines the second step in determining the penalty for violations identified during the patient complaint process, which is to adjust the base penalty by aggravating or mitigating factors. This section considers the following factors, set forth in HSC section 127436 (b)(4), and the specific percentage adjustments the Department will apply to each factor.

- The nature, scope, and severity of the violation, including whether the hospital's policies, postings, and screening practices are in compliance with HSC sections 127405 to 127435, inclusive, or whether the violation was a mistake that resulted in a violation of those policies and practices.
- The facility's history of compliance with related state and federal statutes and regulations.
- Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.
- The demonstrated willfulness of the violation.
- The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.

In determining the specific percentages, the Department referred again to title 22, CCR section 70959. Title 22, CCR section 70959 used adjustment values between five and 20 percent. The Department used this range to determine the adjustments values in this section, taking into consideration the relative seriousness of the factor. The Department deviated from this range when considering a circumstance where the violation involves a hospital's history of compliance with the Act and the hospital's subsequent failure to take appropriate corrective measures. This deviation is explained in more detail, below.

Subdivision (a) sets forth the amount the base penalty shall be adjusted when considering the outlined factors raised in the related subdivisions, below.

Subdivision (a)(1) states that the base penalty will be adjusted upward by 20 percent based on the nature, scope, and severity of the violation, if the required policies, posting, or eligibility screening procedures are not in compliance with HSC sections 127405 through 127435. Title 22, CCR section 70959 did not adjust for this factor in its penalty structure. However, the Department determined that a higher adjustment amount, 20 percent, is necessary to give more significant weight to factors that are likely to be systemic in nature, potentially resulting in widespread violations.

HSC section 127436 (b)(4) requires the Department to take into consideration the facility's history of compliance with related state and federal statutes and regulations. Subdivision (a)(2) provides for adjustment to the base penalty based on the hospital's history of compliance with related state and federal laws. This subdivision further implements the statutory mandate by explaining the laws referenced, the Act and this chapter, and related federal laws, and sets a date of three years for historical reference. The time frame specified for examining a hospital's compliance history is three years. The Department chose a three-year period based on HSC section 1280.3 which provides for administrative penalties against licensed facilities for general violations and uses a three-year historical perspective when considering the hospital's history of compliance.

To further clarify the violations that may be considered when contemplating the hospital's history of compliance, the Department also limited the review to violations of the Act occurring on or after January 1, 2022, and violations of this chapter after the intended effective date of January 1, 2024. As these amended statutes and regulations were not in effect prior to the dates indicated, this clarification is necessary to further define the terms of the historical review.

Subdivision (a)(2)(A) provides for a decrease to the base penalty of five percent if the hospital has no history of violations within the past three years.

Subdivision (a)(2)(B) provides for an increase of five percent if the hospitals have any violations in the past three years.

Subdivisions (a)(2)(A) and (a)(2)(B) are necessary to differentiate between hospitals that have a history of violating related state and federal law and hospitals that do not. By assessing a higher penalty for hospitals that have violations of related state and federal law and a lower penalty for hospitals that do not a history of violations of related state and federal law, the Department is encouraging overall compliance.

Subdivision (a)(2)(C) provides for an increase to the base penalty of 50 percent if the hospital has been assessed a penalty by the Department for violations of the Act in the past three years, if the violation is similar in nature and the hospital was notified of the Department's penalty determination for the violation used to enhance the penalty. This is necessary to encourage future compliance by issuing higher penalties for hospitals that continue to repeat past violations of the Act and associated regulations. By requiring all three criteria to be met for the increase, the Department is ensuring that the

hospital had prior notice that the specific activity was determined to be in violation and that the hospital was given an opportunity to correct the pattern of behavior but failed to make the corrections, perhaps indicating a disregard for the Act and associated regulations.

Subdivision (a)(3) provides for an increase to the base penalty of 20 percent if the violation was caused by a willful act on the part of the hospital. A willful act is defined in subdivision (a)(3)(A) as an intended act or omission by a person, knowing the relevance of the consequences. This is necessary to assess a higher penalty for intentional violations and discourage intentional violations. An adjustment of 20 percent reflects the severity of an intentional violation.

HSC section 127436 did not define "willful violation" in the statute. The Department looked again to CDPH regulations, specifically title 22, CCR section 70952, for guidance. The definition used in this proposed regulation is identical to the definition in title 22, CCR section 70952. This regulation is necessary to clarify a term used in HSC section 127436 and the proposed regulations, and to maintain consistency with other definitions in the regulations.

Subdivision (a)(4) states that the base penalty shall be adjusted downward by 20 percent if there were factors beyond the hospital's control that affected the hospital's ability to comply with the Act. This is necessary to allow for reduction of the penalty when the hospital did not have control over the violation taking place. This mitigation is a common allowance in penalty determinations to allow for externalities, such as third-party interference or disasters which prevented compliance.

Subdivisions (a)(5)(A) through (a)(5)(C) provide for a downward adjustment to the penalty by 20 percent if the hospital identified the violation and initiated corrective action prior to the Department identifying the violation. The hospital must not have received a downward adjustment under subdivision (a)(5) in the previous 12 months. If a hospital receives a complaint from the Department and identifies and rectifies the issues raised before the Department makes its own determination, the hospital will receive the benefit of this mitigation adjustment. This provision is necessary to encourage hospitals, upon receipt of a complaint, to evaluate its own determination, identify its own violations and to promptly fix the issue(s). The Department deviated from the three-year historical perspective in this instance because it determined a 12-month historical perspective, for this factor, will provide a more consistent incentive to hospitals to identify and correct their own violations. A shorter historical perspective will provide the hospitals with more opportunities to access this mitigation factor.

The proposed regulations and the associated penalties are necessary to deter future non-compliant behavior on the part of hospitals.

§ 96051.27. Final Penalty

This section specifies that the final penalty consists of the base penalty as determined under proposed section 96051.25, with any adjustments pursuant to section 96051.26. This is necessary to explain the mathematical construct of addition (for aggravating factors), multiplication (for percentage adjustments), and subtraction (for mitigation) for a total. This section also affirms that the final penalty assessment is never more than statutory maximums. This section is necessary to ensure that the maximum penalty set by HSC section 127436 (b)(4) is followed, even if the sum of the base penalty, adjustments, and any penalties for late responses exceed the maximum set by HSC section 127436 (b)(4).

§ 96051.28. Failure to Reimburse Patient and Pay Assessed Penalty

Under HSC section 127440 hospitals are required to reimburse any money owed to the patient under the Act within 30 days, however it does not designate a start for the 30-day period or a penalty for failure to reimburse.

Subdivision (a) specifies that upon determination by the Department that a violation occurred, and money is owed to the patient, the hospital must reimburse the patient pursuant to HSC section 127440 within 30 calendar days of the final determination, or within 30 calendar days of all appeal rights being exhausted, if an appeal is filed. This section is necessary to establish a start date for the 30-day timeline for the hospital to reimburse the patient.

Subdivision (b) sets a penalty for a failure to properly reimburse the patient, payable to the Department, if the hospital fails to timely reimburse the patient. This penalty is set at $1,000 per day; however, the penalty will not exceed three times the amount owed to the patient, including the interest outlined in HSC 127440. This section is necessary to ensure that the patient is reimbursed any overpaid amount in a timely manner.

For late payment to patients, the Department determined $1,000 per day is appropriate as it mirrors the penalty amount for late filings and late responses of another Department program, the Drug Transparency Act. HSC section 127681 (f) requires drug manufactures to provide reports to the Department under certain circumstances. Failure to provide the report results in a $1,000 per day penalty assessment. Here, the consistent amount of $1,000 will encourage hospitals to timely pay patients the amount they are due. The Department put a cap on the total amount of the penalty, at three times the amount owed to the patient, plus interest, to ensure the amount of the penalty is commensurate with the extent of the violation.

Subdivision (c) outlines that the Department will calculate the penalty and notify the hospital. This section is necessary to ensure the hospital will be notified of the penalty.

§ 96051.29. Small and Rural Hospitals

For penalty assessments of small and rural hospitals, HSC section 127436 (b)(4)(G), requires the Department establish criteria that considers the special circumstances of small and rural hospitals if such a consideration is necessary to protect access to quality care in those hospitals.

Subdivisions (a)(1) through (a)(3) provide an option for small and rural hospitals that have been assessed an administrative penalty to submit a written request for an extended payment plan, if immediate, full payment of the penalty would cause financial hardship to the hospital. Small and rural hospitals may also request reduction of the penalty if extending the payment over a period of time would not resolve the financial hardship to the hospital. This regulation is necessary to provide small and rural hospitals the ability to request special relief when a penalty would cause financial hardship that would jeopardize quality health care in accordance with HSC section 127436 (b)(4)(G).

Subdivision (b) requires the hospital to submit a request to the Department in writing within 10 working days of the issuance of the administrative penalty. While the Department is cognizant of the small staff that a small and rural hospital might possess, the 10 days is consistent with the Department's timeframes for responses and is, in the Department's experience, enough time to either respond or request an extension (set forth in this subdivision). Setting the 10-day period is necessary to ensure the Department can finalize penalties in a timely manner. Further, subdivision (b) requires the hospital to describe how it qualifies for a small or rural hospital designation, the financial hardship it anticipates, and the potential adverse effects on access to care caused by the penalty. This is necessary for the Department to determine whether the hospital qualifies for the relief outline in subdivision (a).

Subdivision (b)(1) provides the hospital the ability to request an extension and subdivision (b)(2) specifies that the Department may grant an extension request depending on a number of factors. This is necessary to provide criteria for the Department's determination and notice to the hospital of the basis on which the determination will be made so that the hospital may address these criteria in its request.

A provision for extension is necessary to give hospitals additional time to submit the required information if warranted.

Subdivision (c) clarifies the Department's determination criteria and sets forth that information relied upon may be sourced from the hospital, the Department itself, and any other governmental agency. The Department will make the determination whether a penalty payment plan or a reduction in fines, or both, are necessary to avoid causing financial hardship that would cause a reduction in access to quality care. This is necessary to clarify the standard for the Department's determination.

§ 96051.30. Penalty Adjustment to Reflect Percentage Change in the Medical Care Index

HSC section 127436 (b)(4) contemplates a change to the maximum imposable penalty every five years based on the Consumer Price Index. Because the proposed regulations regarding calculating the penalty assessment have created a two-step process (base penalty, plus adjustments), clarification of the 5-year adjustment required in HSC section 127436 (b)(4) is necessary. This regulation clarifies the Department will make the adjustment only to the base penalty outlined in the proposed regulations. As the adjustments contemplated in proposed section 96051.26 are percentages of the base fine, it is not necessary to apply the five-year adjustment to these factors. This section is necessary to ensure that the penalties assessed remain consistent with economic conditions as indicated by the statutorily indicated maximums.

§ 96051.31. Corrective Action

AB 1020 tasks the Department with ensuring hospitals comply with the Act. To that end, this section outlines that the Department may require a hospital to take corrective action if the Department determines that the hospital violated the Act or its corresponding regulations. This is necessary to ensure that hospitals fix policies and procedures that are out of compliance with the Act and/or the proposed regulations.

Article 6. Appeals

§ 96051.32. Appeals

HSC section 127436 (c) requires the Department to promulgate regulations to establish a process whereby a hospital may appeal the determination that a violation has occurred, or the amount of any penalty assessed. This section implements the requirement.

Subdivision (a) specifies that hospitals have 30 calendar days from the notice of an accrued penalty to file a written request for an appeal with the Department's hearing officer. This is necessary to ensure a timely appeal process and provide hospitals with a clear and consistent process for requesting an appeal.

Subdivisions (a)(1) through (a)(2) specify hearing requests shall be sent to the Department's hearing officer via U.S. post or email, to the Department hearing officer mailing address or email account. This is necessary to give the hospitals flexibility to file two ways and this subdivision provides detail regarding how a hospital may file the appeal.

Subdivisions (b)(1) through (b)(6) specify the specific information a hospital must provide with its request for hearing: hospital name; name of the hospital's authorized representative for the appeal and their contact information; the name, address, phone number, and email address of the patient and any authorized representative on the complaint; the date of the penalty assessment notice; a statement of the basis for

appeal; and a copy of the penalty notice. This information is necessary for the hearing officer to process the appeal. The contact information for the patient, or the patient's authorized representative is necessary because the hearing officer will notify the patient of the appeal as required by HSC section 127436 (c)(3).

Subdivision (c) requires hospitals to provide a copy of the request for the appeal to the Hospital Fair Billing Program, electronically. This section is necessary to provide the appropriate email address to the hospital and ensure the Hospital Fair Billing Program receives notice of the appeal. Because the hearing unit is separate from the Hospital Fair Billing Program, having the hospital file separately with both groups prevents any prohibited *ex parte* communication from occurring between the hearing unit and the Hospital Fair Billing Program. Thus subdivision (c)'s requirement is necessary for due process and fairness purposes.

§ 96051.33. Communications After Appeal Has Been Filed.

This section clarifies how to appropriately communicate with the hearing officer after the appeal has been filed.

Subdivisions (a)(1) and (a)(2) indicate communications regarding the appeal, other than the initial hearing request, should be directed to the Department's hearing officer when the appeal is being heard by the Department, or directed to the California Office of Administrative Hearing (OAH) when the appeal is being heard by OAH and a case number has been assigned. The Department has discretion to hear matters internally or may refer matters out to California's central panel of administrative law judges at the OAH, within the Department of General Services. Because OAH may not have yet received or processed the appeal, any communications before a case number is assigned (which indicates that a file has been created) may not be appropriately or timely matched to the case file, and so communications should continue with the Department's hearing officer until all parties are notified that OAH is ready to receive communications (as indicated by the sending of a case number). This section is necessary to ensure that communications are properly routed so that they can be appropriately processed.

§ 96051.34. Prehearing Provisions

This section sets forth the prehearing provisions which are necessary to effectuate the appeals process.

Subdivision (a) states hearings shall be set at least 60 days in advance. This is necessary to provide time for the patient to be notified and to give the patient 30 days to respond as required by HSC section 127436 (c)(3). While this may seem like a delay, the 60 days is a standard advance time in hearing processes. All parties may need to set aside time on their calendars, which may include a patient requesting time off or making travel/transportation plans. This also provides time in which parties may make

other requests or arrangements and prepare exhibits and/or witness lists, described below.

Subdivision (b) requires that the hospital and the Department provide all proposed exhibits and list of witnesses to the hearing officer and the opposing party no later than 45 calendar days prior to the hearing. This is necessary to allow sufficient time for the hearing officer to provide the exhibits and witness list to the patient and allow the patient 30 days to respond.

Subdivision (c) states that the hearing officer shall provide the exhibits and witness list to the patient and allow the patient 30 calendar days to submit a response, which may include additional evidence in support of their complaint. This subdivision is necessary to incorporate the requirements of HSC section 127436 (c)(3) into the appeal process. HSC section 127436 (c)(3) requires that the patient who filed the complaint be provided notice of the appeal, a copy of the evidence to be presented, and 30 days to submit a response. The requirement is being duplicated in the regulation to provide the reader a consistent flow for the appeal process.

Subdivision (d) states the hearing officer will share any response received from the patient with the hospital and the Department. This is necessary to ensure the parties will receive the patient's response.

Subdivision (e) states either party may request to change the hearing date. Requests for rescheduling shall be submitted to the hearing officer at least 10 calendar days before the scheduled hearing date. Requests to reschedule shall only be granted if the hearing officer determines there is good cause, and the other party will not be prejudiced. This is necessary to ensure parties have enough time to prepare for the hearing and ensure neither party is prejudiced by undue delays. As a concept for postponements of hearings ("continuances"), "good cause" is a widely understood legal term and may encompass a variety of reasons – from illness, unexpected travel, displacement due to fires, floods, earthquakes, etc., to unexpected evidence emerging. Hearing officers are well-trained to determine good cause and to consider the effects of postponement on all parties. Therefore, this term does not need to be further defined in this section.

Subdivision (f) states all hearings will be held in-person unless the hearing officer opts to schedule the hearing via telephone or other electronic means. If either party objects to a hearing via telephone or other electronic means, the hearing officer will schedule an in-person hearing. If the hearing officer originally scheduled an in-person hearing, either party may request the hearing be conducted via telephone or electronic means. The officer may approve this request at their discretion. The default to an in-person hearing is to give the hearing officer the opportunity to best access the veracity of a witness by observing non-testimonial cues, specifically body language and facial expressions. Alternatively, the hearing officer may determine the hearing can be remote in order to accommodate parties or witnesses that are not local to the hearing location. Giving

either party an opportunity to request an alternative hearing provides the hearing officer the flexibility to determine the most appropriate hearing venue, in-person or remote, based on the nature of the case and the factors raised by the parties.

Subdivisions (g)(1) through (g)(2) state the hearing officer may decide to consolidate the hearing or decision for any number of appeals when the facts are similar, and no party will be prejudiced. Additionally, either party may request consolidation by submitting a request that identifies the appeals for consolidation and the basis. Upon the hearing officer's decision to consolidate appeals, the hearing officer will notify both parties. This is necessary to provide an efficient use of administrative resources and avoid undue delay by duplication when similar issues are raised.

Subdivision (h) specifies if a party or witness of a party needs an interpreter, the party may request interpretation services by filing a request with the hearing officer at least 10 working days before the hearing. This is necessary to ensure access to the hearing for all parties and witnesses, provide the hearing officer with time to arrange for an interpreter, and to avoid the need to reschedule the hearing.

Subdivision (i) states hearings will be electronically recorded; however, either party may provide a court reporter at their own expense. The Department determined electronic records are the appropriate recording mechanism as they are relatively inexpensive, reliable, and are more convenient than court reporters. If a party chooses to use a court reporter, the party will make all necessary arrangements and notify the hearing officer in advance of the hearing. The original transcript shall be provided directly to the Department and the non-appearance of a court reporter shall not be considered adequate grounds for canceling or rescheduling a hearing. This is necessary to permit use of a court reporter, ensure accuracy of the record, as well as timely proceedings.

§ 96051.35. Conduct of Hearing

Section 96051.35 sets forth the way in which the hearing will be conducted in order to ensure the hearings are fair and consistent.

Subdivision (a) explains the hearing may be conducted by a Department appointed hearing officer or an administrative law judge serving as a hearing office at the OAH. This subdivision is necessary because the Department's hearing officer has a variable workload, and it may be necessary for the Department to outsource some hearings to OAH through an interagency agreement to allow greater flexibility in scheduling appeal hearings and increase the overall efficiency of the appeals process.

Subdivision (b) states that the hearing shall not be conducted according to technical rules of evidence and any evidence that is not irrelevant, immaterial, unduly repetitious, or otherwise unreliable or of little probative value shall be admitted. This is necessary to ensure all relevant evidence can be considered by the hearing officer. This provision

also provides consistency with the rules of evidence for administrative adjudications under the California Government Code.[14]

Subdivision (c) states all testimony at the hearing shall be taken under oath or affirmation. This is necessary to ensure the witness testimony is reliable.

Subdivision (d) states the hearing shall be recorded by electronic means unless one party has chosen to provide a court reporter at their own expense, pursuant to 96051.34 (i). This is necessary to ensure that an official record is made and held by the hearing officer.

Subdivision (e) states the hearing shall be open to the public unless a party shows good cause why the hearing should be closed. This subdivision is necessary to provide transparency in the proceeding but also provide the hearing officer the ability to close the hearing as appropriate to protect the privacy of a patient. As discussed above, hearing officers are trained in determining good cause and thus specific criteria need not be listed here.

Subdivision (f) specifies the exhibits, documents, and information related to an appeal are deemed confidential due to financial and medical information contained in the material. This provision is necessary to protect the personal financial and medical information of the patient who filed the complaint.

Subdivision (f) also clarifies that the proposed decision and the final decision will be made public. These documents can be drafted in order to protect the privacy of the individual patient but allow for transparency in the process and the actions of the Department.

§ 96051.36. Settlement

This section states if the Department and hospital reach a settlement prior to the hearing, the Department shall notify the hearing officer and the hearing will be canceled. This is necessary because it allows the Department and hospital to settle the appeal prior to the hearing, resulting in a timely resolution and increasing the overall efficiency of the process. A settlement does not need to be reviewed or approved by a hearing officer, given that the Department Director is the final decisionmaker. Further, the documentation of the settlement would be in writing and so would not need to be recorded by a hearing officer in a hearing.

§ 96051.37. Decision

Section 96051.37 is added to define and provide notice of the process for adoption of a hearing decision by the Director of the Department.

[14] California Government Code 11513(c).

Subdivision (a) states the hearing officer shall prepare a recommended decision in writing for the Director that includes findings of fact and conclusions of law. This is necessary to provide the Director with the information required to make a final determination and uses standard terms of art in administrative hearings, which need no further definition.

Subdivision (b) states the Director may either adopt or reject the proposed decision. If the Director does not adopt the proposed decision, the Director shall independently prepare a decision based upon the hearing record and may adopt the hearing officer's factual findings. This is necessary to ensure the Director makes the final determination regarding the appeal based only on the hearing record and not any external information that would not have been provided during the hearing to the hearing officer. This is a standard tenet of due process.

Subdivision (c) explains the Director's decision shall be final and in writing. This is necessary to provide the reasoning for the Director's final decision for the parties and potential judicial review.

IV. DOCUMENTS RELIED UPON

Assembly Bill 1020 (Friedman, Stats. 2021, ch. 473)
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1020

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

Yale Library, Academic Poster Resources – Accessibility
https://guides.library.yale.edu/academic-poster-resources/accessibility

Guidelines for Creating Accessible Printed Posters
https://www.aucd.org/docs/annual_mtg_2008/accessibility_posters_gilson2007.pdf

What are Accessible Fonts
https://www.accessibility.com/blog/what-are-accessible-fonts

Assembly Committee on Judiciary, Analysis of Assembly Bill 1020 (2021-2022 Reg. Sess.), as amended March 30, 2021.
https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220AB1020

Assembly Committee on Health, Analysis of Assembly Bill 774 (2005-2006 Reg. Sess.), as introduced.
https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=200520060AB774

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

Department of Health Care Access and Information Budget Change Proposal, Fiscal Year 2022-23, Budget Request Name 4140-029-BCP-2022-GB https://esd.dof.ca.gov/Documents/bcp/2223/FY2223_ORG4140_BCP5084.pdf

V. REASONABLE ALTERNATIVES TO THE REGULATION

The Department has determined there are no reasonable alternatives to the regulation. The Department is mandated to promulgate the proposed regulation under AB 1020 and the Act requires the development of a consumer complaint process, appeals process, and process for collecting and reviewing hospital policies. The proposed regulations additionally clarify requirements related to accessibility, patient eligibility, patient notice, and hospital oversight.

The Department invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations during the written comment period. As part of this process, the Department must determine that there is no reasonable alternative identified by the Department or brought to the attention of the Department that would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

VI. BENEFITS OF THE REGULATION

One of the benefits of this regulation is increasing awareness about hospital discount payment, charity care, and the Hospital Bill Complaint Program. This regulation clarifies what hospitals must do to comply with hospital written notice, posting, and website requirements. Currently, hospitals do not have robust notice requirements and patients are less likely to be aware that they may qualify for financial assistance. The requirements of the proposed regulations will help ensure patients are aware of the hospital's discount payment and charity care programs, as well as the Hospital Bill Complaint Program.

Another benefit of the proposed regulations is the creation of a consumer complaint process. If a patient believes they were improperly denied discount payment or charity care, the patient may file a complaint with the Department. The regulation clarifies how a patient, or their authorized representative, may file a complaint through the patient complaint portal. The requirements of this regulation offer patients a possible recourse if a hospital improperly denies their discount payment or charity care application.

The regulation also describes the process for the Hospital Bill Complaint Program to collect and review hospital discount payment and charity care policies. By clarifying the policy submission requirements, document requirements, policy review process, and substantive policy requirements, it is more likely that hospital policies will comply with the Act.

Lastly, the regulation specifies penalties for hospital violations by establishing criteria for determining penalty amounts, as well as an appeal process. By clarifying the penalty amounts as well as the process to calculate any administrative penalties, hospitals will have increased transparency regarding penalty assessments. Penalties will also benefit patients because they will deter hospitals from future out of compliance behavior.

VII. ECONOMIC IMPACT ASSESSMENT/ANALYSIS

This regulation package is intended to address multiple issues as directed by the Act. The below analysis is limited to the economic impact incurred as a result of the proposed regulations. The analysis does not contemplate the economic impact resulting from legal obligations already imposed by HSC sections 127400, *et seq.* The proposed regulations will only impose requirements on hospitals regulated by HSC section 1250 (a), (b) and (f).

The proposed regulations provide guidance and clarity on the submission of documents, specifically, policies for discount payment, charity care, debt collection, and applications. Prior to implementation of these regulations, hospitals were required to submit these documents to the Department. These proposed regulations provide guidance on how they are to be submitted and clarify the requirements for the documents. The requirements added by the proposed regulations will not impact the workforce needs of the hospitals.

Additionally, the Act requires the Department to develop a complaint process and an appeal process for potential violations of the discount payment and charity care programs required by the Act.

The Department determined that the complaint process adopted in the proposed regulations will potentially require a small amount of additional work for hospital employees as the process will require hospitals to respond to inquiries from the Department regarding complaints filed by patients. However, the patient complaint process was previously created by statute, so any additional workload imposed by these regulations should be minimal and absorbable.

To estimate a potential number of complaints likely to be filed, the Department reviewed data from the 2019 Hospital Annual Financial Data - Selected Data & Pivot Tables - Datasets – (Pivot Table) located on the California Health and Human Services Open

Data Portal.[15] According to the Pivot Table, for 2019, of all hospital patient revenue, bad debt made up .776% (numbers were slightly lower for more recent data in 2020, possibly because of the pandemic). The Department, in its Budget Change Proposal (BCP)[16], to fund the Hospital Fair Billing Program, estimated approximately 1% of the bad debt bills, or .007% of all patient bills, will result in a complaint with the Department.

Given the number of cases is likely to be less than .01% of all patient bills, the Department has determined the number of cases per hospital will be low and will likely be absorbed by the existing hospital workforce.

The Act also requires that hospitals provide notice to patients about discount payment and charity care programs at the time of discharge. The proposed regulations require that this discharge notice be provided in hard copy format. The proposed regulations also add an additional requirement that hospitals respond to patient applications for discount payment and charity care in writing. Hospitals were previously required to make eligibility determinations, but there was no requirement that the hospital provide a written determination. This additional requirement will have a minimal impact on the workforce needs of hospitals but will result in additional annual costs of $1,130,715.00 statewide for all hospitals, or $2,877.14 per hospital.

The Department calculated these costs as follows:

The Department estimates the costs to provide hard copy discharge notices to every patient will be $779,532.17 statewide. To reach this estimate, the Department sourced the cost of commercially available printer paper available at $5.89 per ream of paper. Each ream of paper contains 500 sheets. The cost of paper for one printed notice would be $0.012. The Department also sourced the cost of commercially available toner for a copy machine at $160 per toner cartridge. One toner cartridge yields 59,000 pages. The cost of toner for one printed notice would be $0.003. Adding the cost of $0.012 per sheet of paper and $0.003 for the toner used for one printed page, the total cost of one printed notice would be $0.015. Using the 2019 number of 51,968,811 from the pivot table, patient bills multiplied by $0.015, the estimated total cost for hard copy discharge notices is $779,532.17.

The Department estimates the cost of the eligibility letter to be $351,183.00 statewide. According to the Pivot Table, of the 51,968,811 patient bills in 2019, 401,352 of those bills are considered bad debt. The Department is using this figure to estimate how many

[15] 2021 Pivot Table – Hospital Annual Selected File (October 2022 Extract) https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/29bacfe7-a98d-4183-9282-a5803a3d4c6e?view_id=0e379425-1e60-4868-8064-d8d9a3c74e0a

[16] Department of Health Care Access and Information Budget Change Proposal, Fiscal Year 2022-23, Budget Request Name 4140-029-BCP-2022-GB

discount payment and charity care applications hospitals may receive. Using the previously estimated cost of $0.015 per printed notice, $0.23 per envelope for mailing, and $0.63 per letter for metered mail (currently $0.60, but scheduled to increase to $0.63 in July 2023), and multiplying that by the estimated 401,352 applications received by the hospitals, the cost of mailing these eligibility letters to all applicants would be $351,183.00.

The statewide cost of the discharge letter, added together with the cost of the eligibility letter equals a statewide annual cost of $1,130,715.17, or an average of $2,877.14 per licensed hospital.

AB 1020 also requires hospitals to post notice of the hospital's policies for financially qualified patients on its website and in locations within the hospital that are visible to the public. The proposed regulations clarify the requirements of AB 1020, by providing specific provisions as to how this information should be displayed, both publicly and on the website. This may require hospitals to make changes to their current public postings and websites to satisfy the proposed regulations. The Department determined the cost of printing new posters will be approximately $10.62 per hospital.

The costs of the posters are calculated as follows: The Department estimates the cost to print hard copy informational posters to be placed in the statutorily required locations will be $4,173.66 statewide, or $10.62 per licensed hospital. There are 393 hospitals regulated by the proposed package. The Department estimates that hospitals will need to print, on average, 10 posters to be placed in each hospital's emergency department, billing office, admissions office, and other outpatient settings, including observation units. The proposed regulations specify that these posters must be printed on 11" x 17" paper. The Department sourced the cost of commercially available card stock paper, since posters are generally printed on thicker paper. The cost of commercially available 11" x 17" card stock is $52.99 per ream of card stock. One ream of card stock contains 50 sheets. The cost of card stock for one printed poster would be $1.059. The Department also sourced the cost of commercially available toner for a copy machine at $160 per toner cartridge. One toner cartridge yields 59,000 pages. The cost of toner for one printed poster would be $0.003. Adding the cost of $1.059 per sheet of card stock and $0.003 for the toner used for one printed poster, the total cost of one printed poster would be $1.062. Multiplying the cost of one printed poster by 10 (for the average number of posters each hospital is estimated to need) yields a cost of $10.62 per hospital and $4,173.66 statewide.

The cost of updating the website to meet the new requirements will be absorbed by the hospital's IT staff.

Additionally, although the proposed regulations do not change the eligibility requirements, they do clarify eligibility issues. For example, in reviewing current hospital policies, the Department has noted that some hospitals exclude certain medically necessary services from discount payment eligibility. These current policies appear to

be in violation of the Act as it does not provide for such exclusions. The regulations clarify that all medically necessary services are eligible for discount payment. This clarification will likely require hospitals to perform a review of its policies and applications to confirm that they are in compliance with the Act as clarified in the proposed regulation. Based on this analysis, the Department has concluded the following:

Fiscal Impact. These regulations will not have any additional fiscal impact. The Department previously completed a BCP based upon the passage of the Act. The BCP contemplated creating the Hospital Fair Billing Program, tasked with the implementation and enforcement of the Act. The BCP was previously approved by the legislature. The Department does not anticipate additional funds beyond what was requested and approved in the BCP.

Housing Cost. This proposal will not result in any change to housing costs.

Statewide Adverse Economic Impact. This regulation applies evenly to all hospitals within California and will not impact competitiveness between in-state hospitals and out-of-state hospitals. Hospitals, by their nature, are generally location centric and are not competing with businesses outside the state, therefore the proposal will not have a statewide economic impact.

Creation or Elimination of Jobs Within the State of California. This proposal will not result in the increase or elimination of jobs within the State of California.

Creation of New Businesses or the Elimination of Existing Businesses Within the State of California. This proposal will not have any impact on the creation of new businesses or the elimination of existing businesses within the State of California.

Expansion of Business Currently Doing Business Within the State of California. This proposal will not result in the expansion of businesses currently doing business within the State of California.

Benefits to the Health and Welfare of California Residents. This regulatory action is likely to benefit the health and welfare of California residents. The amendments to HSC sections 127400, *et seq.,* were designed to inform patients of the availability of financial assistance, increase eligibility of uninsured and underinsured patients for financial assistance, impose additional requirements for collection of medical debt, and authorize the Department to enforce hospital compliance with the requirements of HSC sections 127400, *et seq*. The proposed regulations will make discount payment and charity care more accessible, ensuring those who qualify for assistance receive the financial assistance intended.

This regulatory action is unlikely to benefit worker safety and the State's environment. The proposed regulations do not regulate worker safety standards or change any applicable environmental standards.