INITIAL STATEMENT OF REASONS

HOSPITAL EQUITY MEASURES REPORTING PROGRAM

CALIFORNIA CODE OF REGULATIONS
TITLE 22, DIVISION 7, CHAPTER 8.4
SECTIONS 95300 TO 95316

April 15, 2024

Pursuant to California Government Code Section 11346.2, the California Department of Health Care Access and Information (HCAI) hereby presents its initial statement of reasons for its proposed regulations regarding the Hospital Equity Measures Reporting Program.

I. BACKGROUND INFORMATION

Signed into law, Assembly Bill (AB) 1204 (Wicks, Chapter 751, Statutes of 2021) creates the Medical Equity Disclosure Act (Act), Health and Safety Code (HSC) Section 127370 et seq., requiring hospitals and hospital systems to file an annual equity report with HCAI. Hospitals and hospital systems shall also post a link to their equity reports on the main page of their internet websites. While HCAI currently collects healthcare facility-level reports for financial and utilization data and patient-level data from hospitals, these new annual reports are required to include data related to patient access, quality, and outcomes by race/ethnicity, age, preferred language, disability status, sexual orientation, gender identity, and expected payor. The equity reports are due annually by September 30th with the first report due September 30, 2025. The report must also include a plan to prioritize and address disparities for vulnerable populations identified in the data. AB 1204 authorizes HCAI to impose a fine up to $5,000 on hospitals for failure to submit a health equity report consistent with the requirements.

In addition to the new equity report collection, HCAI is required to convene a Hospital Equity Measures Advisory Committee (HEMAC), which provides recommendations on the development of measures as well as provide recommendations on the measurable objectives and specific timeframes for hospitals and hospital systems to develop their plans to prioritize and address disparities for vulnerable populations identified in the data. The first HEMAC meeting was convened on July 7, 2022.

HCAI is proposing to adopt regulations to implement the Act in the California Code of Regulations, Title 22, Division 7, Chapter 8.4, Sections 95300 - 95316.

II. THE PROBLEM TO BE ADDRESSED

New regulations are required to implement the Act, which requires hospitals and hospital systems to submit an equity report with data stratified as specified in Section 95301 of the proposed regulations, to the extent the data is available, as determined by each hospital and hospital system. Provisions of the Act must be interpreted and made specific for the regulated hospitals and hospital systems to comply with statutory requirements. Therefore, regulations are required to successfully establish this statutorily mandated Hospital Equity Measures Reporting Program.

III. THE PURPOSE AND BENEFITS OF THIS REGULATORY ACTION

The purpose of the proposed regulations is to implement, interpret, and make specific requirements for hospital equity reporting and submissions of hospital equity plans that prioritize and address disparities for vulnerable populations identified in reported data, based on the recommendations of HEMAC.

The benefits of the regulations are to achieve the goals of the Act by identifying disparities to detected areas where certain groups or populations face inequality in access, treatment options, and health outcomes. Another benefit of the proposed regulations is to promote transparency by making the equity reports in which the hospitals analyze access to and quality of care by age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and socioeconomic status available to the general public.

One impact of the proposed regulations is to standardize reporting requirements of structural and quality measures, including the method of submission. Specifying the submission method in these proposed regulations will greatly improve the efficiency of reporting by hospitals and hospital systems and allow for greater comparability across hospitals.

Another impact of the proposed regulations is standardizing key definitions in order to help hospitals and hospital systems understand core concepts and accurately implement the requirements of the statute. Clear stratification categories similarly enable reliable grouping and analysis of patient populations across hospitals and hospital systems.

The proposed regulations also clarify hospital contact information and registration, allowing for efficient communication channels. Additionally, the proposed regulations

establish firm timetables for deliverables, paired with protocols for deadline extensions and fines for failure to submit reports to ensure timely reporting, as well as information regarding hearing requests and decisions, and settlement.

IV. NECESSITY

The addition of Chapter 8.4 of Division 7 of Title 22, sections 95300 - 95316, is necessary to implement the Act. The regulations interpret and provide specificity regarding the various components of the Act to implement standardized reporting requirements of the mandated program.

V. SPECIFIC PURPOSE OF EACH SECTION

Article 1: General
§ 95300. Definitions

Section 95300 is added to provide definitions to terms used in Article 1 through 3 of the proposed regulations. The definitions are necessary to ensure that the program regulations that follow meet the clarity requirement and to provide the specificity necessary for compliance with the regulations and implementation of the reporting requirements mandated by Article 2. Definitions in subdivisions (a), (b), (c), (d), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), and (u) are necessary to clarify the use of the terms in the Hospital Equity Report: Measures Submission Guide, dated April 15, 2024, referenced in the text of the proposed language.

Subdivision (a) defines “Acute psychiatric hospital” as the term as defined in HSC Section 1250, subdivision (b). The proposed regulation is necessary to clearly outline the criteria for defining an acute psychiatric hospital.

Subdivision (b) defines “Children’s Hospital” as a hospital annually identified by the Department using the following criteria: children’s hospitals identified by Welfare and Institutions Code Section 10727, (including hospitals operating under a different name, but otherwise the same entity) or a hospital that has an inpatient population of more than seventy-five percent (75%) of individuals eighteen (18) years of age or younger, as identified by the Department’s Patient Discharge Data. Analysis of this determination shall be conducted annually using the same data year as the year reported in the hospital equity report. The proposed regulation is also necessary to clearly outline the criteria for defining a children’s hospital.

Subdivision (c) defines “Department” as the Department of Health Care Access and Information. This provision is necessary to clarify the use of the term Department in proposed regulations.

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

Subdivision (e) defines “Disparity” as differences in access to or availability of medical facilities and services and variation in rates of disease occurrence and outcomes between population groups defined by socioeconomic characteristics, race/ethnicity, age, sex assigned at birth, expected payor, preferred language, disability status, sexual orientation, and gender identity. This definition was adopted from the Agency for Healthcare Research and Quality (AHRQ) (https://www.ahrq.gov/topics/disparities.html).

Subdivision (f) defines “Disparity reduction” as a reduction in variation in access, availability of medical facilities and services, disease occurrence, including communicable diseases and chronic conditions, as well as health outcomes for vulnerable populations. This definition is consistent with HSC Section 127371, subdivision (b).

Subdivision (g) defines “Equity report” or “report” as a document prepared for annual submission to HCAI pursuant to this article. This definition clarifies the definition in HSC Section 127371, subdivision (c) by specifically stating that a report includes data, stratification, and the required health equity plan.

Subdivision (h) defines “General acute care hospital” as the term is defined in HSC Section 1250, subdivision (a). The proposed regulation is necessary to clearly outline the criteria for defining a general acute care hospital.

Subdivision (i) defines “Hospital” as an acute hospital licensed pursuant to subdivision (a), (b), or (f) of HSC Section 1250. This definition is consistent with HSC Section 127371, subdivision (d). Additionally, it provides clarity in the regulations as to the entities required to submit an equity report to HCAI annually.

Subdivision (j) defines “Hospital type” as the four different types of hospitals that are required to be submitting equity reports. Given that the different types of hospitals, based on their patient populations and focus areas, have different measures on which they are required to report, this regulation is necessary to provide that clarification as to which type of hospital is being referred to.

Subdivision (k) defines “Hospital system” as an entity or system of entities that includes or owns two or more hospitals within the state, of which at least one is a general acute care hospital, as defined in subdivision (a) of HSC Section 1250. Hospital system also means a single corporation or entity which controls two or more hospitals and an integrated system as defined in HSC Section 127371, subdivision (f). A single consolidated license with multiple plants does not constitute a “hospital system.” The

proposed definition is also necessary to clearly outline the criteria for defining a hospital system. Language in the Act does not sufficiently identify requirements of corporations, entities, or systems of entities to submit an equity report. The proposed definition also clarifies that hospitals operating under a single consolidated license do not qualify as a hospital system. This further clarifies that hospital system status is determined at the license level.

Subdivision (l) defines “Measures” as a set of metrics used to assess accessibility, quality, and outcomes of healthcare services provided by hospitals or hospital systems. This provision provides a standardized methodology for all hospitals and hospital systems to follow when conducting their analysis.

Subdivision (m) defines “Measures Submission Guide” as the Hospital Equity Report: Measures Submission Guide, dated April 15, 2024, and the Measures Submission Guide is incorporated into the regulations by reference. This document is incorporated by reference because it is in a format that is cumbersome and impractical to publish the document in the California Code of Regulations. The Measures Submission Guide is available on the HCAI website. This provision is necessary to provide clear technical guidance to hospitals and hospital systems in preparing and submitting equity reports, thereby avoiding confusion and errors that may lead to delay and/or non-compliance.

Subdivision (n) defines “Patient population” as all of the people served by a hospital. This definition is consistent with HSC Section 127371, subdivision (g).

Subdivision (o) defines “Plants” as physical facilities on a single consolidated license as determined by the California Department of Public Health (CDPH). This provision also specifies that plant includes parent and consolidated hospitals as determined by CDPH. This provision is necessary to specify that each plant will be required to submit separate hospital equity reports.

Subdivision (p) defines ‘Rate ratio” as a comparison of the rate between a stratification group and the reference group for each measure. This provision is necessary to clarify language in the Measures Submission Guide referenced in the text of the proposed regulations. Additionally, this provision provides a standardized methodology for all hospitals to follow when conducting their analysis, leading to more comparable analyses across hospitals and hospital systems.

Subdivision (q) defines “Reference group” to refer to the group with the best performing outcome for a measure within a stratification category at hospital level or system level. Additionally, this provision provides a standardized methodology for all hospitals and hospital systems to follow when conducting their analysis, leading to more comparable analyses across hospitals and hospital systems.

Subdivision (r) defines “Special hospital” as the term as defined in HSC Section 1250, subdivision (f). The proposed regulation is necessary to clearly outline the criteria for defining a special hospital.

Subdivision (s) defines “Stratification category” as the categories by which each measure has to be stratified. The stratification categories are listed in Section 95301 which are race/ethnicity, age, sex assigned at birth, expected payor, preferred language, disability status, sexual orientation, gender identity, and behavioral health diagnosis.

Subdivision (t) defines ‘Stratification group” to refer to the specific group within each stratification category listed in stratification tables of the Measures Submission Guide. This provision provides a standardized methodology for all hospitals and hospital systems to follow when conducting their analysis, leading to more comparable analyses across hospitals and hospital systems.

Subdivision (u) defines “Vulnerable populations” pursuant to Health and Safety Code Section 127371, subdivision (h) to include both of the following:

(1) Racial and ethnic groups experiencing disparate health outcomes, including Black/African American, American Indian, Alaska Native, Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, or other nonwhite racial groups, as well as individuals of Hispanic/Latino origin, including Mexicans, Mexican Americans, Chicanos, Salvadorans, Guatemalans, Cubans, and Puerto Ricans.

(2) Socially disadvantaged groups, including all of the following:

a. The unhoused.
b. Communities with inadequate access to clean air and safe drinking water, as defined by an environmental California Healthy Places Index score of 50 percent or lower.
c. People with disabilities.
d. People identifying as lesbian, gay, bisexual, transgender, or queer.
e. Individuals with limited English proficiency.

This is necessary, as it outlines the population types that hospitals are required to consider when identifying the top 10 disparities in the data as outlined by HSC Section 127372, subdivision (d)(1).

§ 95301. Stratification Categories

Section 95301 specifies the stratification categories required for the measures in the equity reports submitted by hospitals and hospital systems. These are derived from the definition of vulnerable populations in the Act:

a. Race/Ethnicity

b. Age
c. Sex Assigned at Birth
d. Expected Payor
e. Preferred Language
f. Disability Status
g. Sexual Orientation
h. Gender Identity
I. Behavioral Health Diagnosis (Additional stratification for HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate only)

This section is necessary to standardize the stratification categories on which hospitals and hospital systems are required to report. The Measures Submission Guide dated April 15, 2024, further specifies the stratification groupings for each of these categories.

§ 95302. Hospital Contact Information and Registration

Section 95302 is added to specify requirements for hospitals and hospital systems when registering with the Department.

Subdivision (a) specifies that a hospital and a hospital system shall designate primary and secondary contact persons who must register with the Department for the purpose of receiving compliance and informational communications, receiving advanced notice of report due dates, and submitting the required report. This provision is necessary to ensure the Department has designated individuals to contact regarding requested information and responses. This provision also specifies that the designated contact persons for hospital systems are permitted to submit both hospital system and individual hospital equity reports. This provision clarifies that statutory allowance in Section 127373, subdivisions (b) and (c) for integrated systems and systems under the common control of a single corporation or another entity may have one contact person submit the reports on behalf of all individual hospitals within the system and the hospital system report.

Subdivisions (b)(1) through (b)(7) specify the information required from the hospital's and hospital system's designated primary and secondary contact persons to register in the Department's online reporting system. This provision is required for the Department to identify the primary and secondary contact persons and to contact each person as needed.

Subdivision (c) specifies the requirement that hospitals and hospital systems shall inform the Department within a specified number of days of any changes specified in subdivision (b)(1) through (b)(7). This provision ensures that the Department has access to the most up-to-date contact information of the primary and secondary contact persons for the purposes of receiving compliance and informational communications. This provision also ensures that hospitals have active primary and secondary contact

persons registered on the Department's online reporting system. This is necessary to mitigate communication issues leading to non-compliance.

Subdivision (d) specifies that the primary contact person for each hospital and hospital system shall identify individuals who may use the Department's online report submission portal on behalf of the hospital or hospital system. This language is included in the regulations to allow primary contact persons to designate other individuals to access and submit the reports on behalf of the hospital or hospital system. This provision is necessary to minimize the chances that a hospital or hospital system will fail to comply with reporting mandates.

Article 2: Hospital Equity Report Submission
§ 95303. Hospital Equity Report

Section 95303 is added to specify requirements of the hospitals specified in subdivisions (e), (f), (g) and (h) to submit their equity reports and the report elements required.

Subdivision (a) specifies that hospitals are required to submit an equity report and further specifies that each hospital plant on a consolidated license shall submit separate equity reports. This subdivision also specifies that the data needs to be stratified to the extent that it is available and needs to be consistent with the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016. This is necessary to ensure adherence to HSC 127373, subdivision (d), which requires the data to be submitted to the extent information is available and disclosed in a manner that protects the personal information of patients pursuant to state and federal privacy laws.

Subdivision (b) specifies that the equity reports must meet the requirements of the Measures Submission Guide which is needed to clarify that the submission guide includes further specifics on stratification categories.

Subdivision (c) clarifies what measure data shall be included in the equity reports to the extent data is available. This provision is necessary to clarify how measures are reported to the Department and to establish a standardized reporting process.

Subdivisions (d)(1) through (d)(8) specify the report information all hospitals shall submit, regardless of facility type including: hospital name, HCAI ID, report period, whether hospital is located in an area with access to clean water and air (by selecting a checkbox), the web address where a hospital's equity report is published, a health equity plan as outlined in subdivisions (8) (A) (B) and (C), and the explanation of the methodology used in their reports. As communities with inadequate access to clean air and safe drinking water are identified as vulnerable populations, capturing this data allows a hospital to ensure they prioritize that population in their equity report. It also

provides greater transparency by making that information available to the general public. These provisions are necessary to ensure all hospitals, regardless of facility type, are meeting all requirements for data submission as specified in the Act. Further, HSC Section 127373, subdivision (a)(3) mandates that hospitals post their hospital equity report on the hospital's website. Including web address information in this provision as a required report element promotes transparency and accessibility to the general public, consistent with the Act's purpose. In addition, HSC Section 127372, subdivision (b) mandates that an equity report include a plan to prioritize and address disparities for vulnerable populations. As communities with inadequate access to clean air and safe drinking water are identified as vulnerable populations, capturing this data allows a hospital to ensure they prioritize that population in their equity report. It also provides greater transparency by making that information available to the general public. Finally, this provision implements HSC Section 127373, subdivision (a)(1) which mandates that hospitals include an explanation of their methodology. The Measures Submission Guide provides a standardized methodology hospitals may follow when analyzing their data. If a hospital follows a different methodology, they are required to explain their methodology.

Subdivision (e) lists the measure types as structural measures and core quality measures for general acute care hospitals. This provision is necessary to specifically outline the measures that general acute care hospitals are required to report. This subdivision also specifies the measures that shall be stratified according to the guidelines in Stratification Table 1 and Stratification Table 2 in the Measures Submission Guide. These guidelines are consistent with the data requirements outlined in the Act. After the Department considered measure recommendations from HEMAC for general acute care hospitals, the Department conducted additional workshopping with hospitals and reviewed additional internal analyses of the proposed measures to select the final requirements. To review the recommendations from HEMAC, see the measures recommendations report: https://hcai.ca.gov/wp-content/uploads/2023/02/HCAI-HospitalEquityMeasuresCommitteeReport2022-finalv02.03.23-ADA.pdf.

Subdivision (f) lists the measure types as structural measures and core quality measures for children's hospitals. This provision is necessary to specifically outline the measures that children's hospitals are required to report. This subdivision also specifies the measures that shall be stratified according to the guidelines in Stratification Table 1 and Stratification Table 2 in the Measures Submission Guide. These guidelines are consistent with the data requirements outlined in the Act. After the Department considered measure recommendations from HEMAC for children's hospitals, the Department conducted additional workshopping with children's hospitals and reviewed additional internal analyses of the proposed measures to select the final requirements. To review the recommendations from HEMAC, see the measures recommendations

report here: https://hcai.ca.gov/wp-content/uploads/2023/02/HCAI-HospitalEquityMeasuresCommitteeReport2022-finalv02.03.23-ADA.pdf.

Subdivision (g) lists the measure types as structural measures and core quality measures for acute psychiatric hospitals. This provision is necessary to specifically outline the measures that acute psychiatric hospitals are required to report. This subdivision also specifies that the measures shall be stratified according to the guidelines in Stratification Table 1 and Stratification Table 2 in the Measures Submission Guide. These guidelines are consistent with the data requirements outlined in the Act. After the Department considered measure recommendations from HEMAC for acute psychiatric hospitals, the Department conducted additional workshopping with acute psychiatric hospitals and reviewed additional internal analyses of the proposed measures to select the final requirements. To review the recommendations from HEMAC, see the measures recommendations report here: https://hcai.ca.gov/wp-content/uploads/2023/02/HCAI-HospitalEquityMeasuresCommitteeReport2022-finalv02.03.23-ADA.pdf.

Subdivision (h) lists the measure types as structural measures and core quality measures for special hospitals. This provision is necessary to outline the measures that special hospitals are required to report on and shall follow the measures specified for general acute care hospitals, where applicable.

§ 95304. Hospital System Equity Report

HSC Section 127372, subdivision (c) mandates that hospital systems with more than one hospital submit an equity report, which is defined as both the data analysis and health equity plan, disaggregated at the individual hospital level, and aggregated across all hospitals in the system. Section 95304 is added to specify requirements of hospital systems to submit equity reports, including the specified report elements. In order to successfully submit a system report, the Department has outlined clear requirements for hospital systems. While the statute did not mirror requirements for hospitals and hospital systems across all requirements, the Department did extend certain requirements to hospital systems in order to facilitate efficient submission of the reports and build out a more effective transparency program that furthers the objectives of the Act. This includes extending the requirements for specific data elements, and methodology to be included in system reports. It also includes providing hospital systems with an opportunity to request an extension for submission of an equity report. Additionally, the Department does extend the Data De-Identification provisions to hospital systems to ensure that the reports that are submitted are still adhering to those privacy standards. While the Department did not extend the provision to penalizing hospital systems for not submitting a report, given that the statute only authorizes the Department to penalize a hospital, to enhance transparency and uphold the legislative intent, the Department plans to list hospital systems that fail to submit a report on the

HCAI website. Finally, while the statute requires hospitals to post their equity reports on their websites, this requirement is not extended to hospital systems; however, to support the spirit of transparency that the law is invoking, the Department has outlined that hospital systems have the option to post the equity report on their websites, although it is not a mandated requirement.

Subdivision (a) specifies that hospital systems are required to submit a hospital system equity report. Subdivisions (b)(1) through (b)(9) specify the report information including hospital system name, hospital system ID, hospital system CEO, report period, and all hospitals in the system. The system report is required to aggregate data across all individual hospital reports by facility type within the hospital system. This provision implements HSC Section 127372, subdivision (c) and is necessary to specify the requirements for hospital system equity reports. This provision also provides the necessary specificity to ensure that the data is correctly aggregated, given that there are different reporting requirements for the four different hospital types specified in the definitions. Additionally, this provision specifies that all core quality measures and all structural measures, except one, must be reported at the hospital system level. This is to clarify which measures are feasibly reported at a hospital system level. This subdivision also specifies that the data needs to be stratified to the extent that it is available and needs to be consistent with the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016. This is necessary to ensure adherence to HSC 127373, subdivision (d), which requires the data to be submitted to the extent information is available and disclosed in a manner that protects the personal information of patients pursuant to state and federal privacy laws. In addition, subdivision (b) mandates that an equity report include a plan to prioritize and address disparities for vulnerable populations.

Subdivision (c) clarifies that a hospital system equity report is not a substitute for an individual hospital equity report. This provision is necessary to clarify that HSC Section 127372, subdivision (c) specifies that hospital systems are required to submit both an individual hospital report for each hospital within their system, pursuant to Section 95303, and a report that is aggregated across the system as specified in Section 95304, subsections (a) and (b).Subdivision (d) specifies that a hospital system shall post the hospital system's equity report on the hospital system's website, if one is available. Subdivision (d) also specifies that the hospital system may include in its equity report the web address of the hospital system equity report. This provision is necessary to ensure equity reports are accessible for transparency and public access.

§ 95305. Equity Report Supplemental Document (Optional)

Section 95305 specifies the requirements of an equity report supplemental document (Supplemental Document). A Supplemental Document is optional for hospitals and hospital systems to submit and may be used to supplement the information reported in

equity reports required by Sections 95303 and 95304. Although a Supplemental Document is not required, this provision is necessary to establish the requirements if one is submitted. As described below, these requirements are necessary to ensure accessibility and consistency.

Subdivision (a) specifies the required file type for a Supplemental Document that hospitals and hospital systems may submit to the Department. A Supplemental Document shall be in Portable Document Format (.pdf). This provision is necessary to ensure accessibility for the public when viewing a Supplemental Document. Creating pdf documents is readily available to hospitals and hospital systems and does not create an additional expense for hospitals or hospital systems.
Subdivision (b) specifies that a Supplemental Document shall be machine-readable. This provision is necessary for accessibility, including allowing the public and the Department to easily find information within a Supplemental Document. Subdivision (c) specifies that all data and information in a Supplemental Document shall conform to the requirements in the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)", dated September 23, 2016. This is necessary to ensure adherence to HSC 127373, subdivision (d), which requires the data to be submitted to the extent information is available and disclosed in a manner that protects the personal information of patients pursuant to state and federal privacy laws.

§ 95306. Reporting Period and Report Due Date

Section 95306 specifies the reporting period hospitals and hospital systems shall use for reporting data and for completing the accompanying health equity plan. This section also clarifies a due date for hospitals and hospital systems to submit their equity reports.

Subdivision (a) specifies the reporting period as a calendar year spanning January 1 to December 31. This is necessary to provide clarity on the timeline that hospitals and hospital systems shall use when preparing equity reports.

Subdivision (b) is added to provide clarification on the required equity report due date. Pursuant to HSC Section 127372, subdivisions (b) and (c), hospitals and hospital systems shall annually submit their equity reports to the Department no later than September 30th for the prior calendar year reporting period.

Subdivision (c) provides that if the Department's online reporting system is unavailable for report submission for one or more periods of four (4) or more continuous hours during the four (4) State working days prior to a due date, the Department shall extend the report due date by seven (7) days for the submission of the equity report. This provision acknowledges that technical issues with the online reporting system may affect a hospital's or hospital system's ability to submit its report and meet the compliance requirements.

§ 95307. Extension Request

Section 95307 is added to provide clarification on how a hospital or hospital system may request an extension for their required report.

Subdivision (a) specifies that a hospital or hospital system may request an extension of a due date consistent with HSC Section 127374, subdivision (b). Subdivision (a) also specifies that the Department may grant a hospital or hospital system a single 60-day extension per report period upon request.

Subdivision (b) specifies that a registered contact person of a hospital or hospital system may file a request with the Department for an extension on or before a due date via the online reporting system and will not be subjected to a fine. Subdivision (b) also states that extension requests not filed by a due date will accrue fines as prescribed in Section 95310, subdivision (b). Subdivision (b) also states that the Department will send an email notice of approval or rejection to the registered contact person(s), which may include a new due date. Upon request by the registered contact person(s), the online report submission portal will automatically evaluate the extension request and promptly provide an approval or denial based on its request availability. This provision is necessary to streamline the process which aims to expedite the review and response to extension requests, ensuring efficiency and convenience for the users.

Subdivision (c) outlines the process for notifying the requestor of the extension request decision. Upon approval, the Department will send an email confirmation to the requestor, confirming the extension request has been approved and that a due date has been extended 60 days. In cases of a denial, the Department will send an email confirmation, informing the requestor of the denial of the extension request. This provision is necessary to ensure that the requestor receives confirmation of a decision from their extension request.

§ 95308. Method of Submission

Section 95308 is added to specify the required method to submit reports filed pursuant to Sections 95303 and 95304.

Subdivision (a) specifies that reports shall be submitted electronically through the Department’s website using a report submission portal. This is necessary to provide a streamlined and clear submission process for reporting hospitals and hospital systems. This subdivision also provides the submission portal web address.

Subdivision (b) specifies that a hospital and hospital system shall submit equity reports using one of two methods. To accommodate differences and preferences among hospitals and hospital systems, the Department selected two options for submission as described below.

Subdivision (b)(1) specifies that submitters have the option of uploading files for the required information on the Department’s online report submission portal. Uploaded files

shall be in comma separated values (.csv) file format and comply with the Department's Format and File Specification for Submission of the Equity Report Version 1.0, dated April 15, 2024, referenced in the text of the proposed regulations. This document is incorporated by reference because it is in a format that is cumbersome and impractical to publish the document in the California Code of Regulations. This provision is necessary to clarify the specific format requirements for uploaded files and provide the necessary information to hospitals and hospital systems to meet the requirements for filing an equity report through this submission method.

Subdivision (b)(2) specifies that the components of an equity report may be manually entered in the Department's online report submission portal. This is necessary to specify another option for submitters to file an equity report.

Subdivision (c) specifies the required file type for hospitals and hospital systems that choose to submit an optional Supplemental Document, as detailed in Section 95305. Hospitals must submit that document in a Portable Document File (.pdf) machine-readable format in accordance with Government Code Section 11546.7. This is necessary to ensure accessibility for the public when viewing Supplemental Documents. Creating pdf documents is readily available to hospitals and hospital systems and does not create an additional expense for hospitals and hospital systems.

Subdivision (d) specifies the requirements for report certification. Reports shall include certification language stating the information and data contained in the report is true, correct, and complete. This provision is necessary to implement the program for collecting equity reports and to ensure reports comply with the requirements as stated in the Act and any adopted regulations.

Article 3: Fines and Appeals

§ 95309. Fines for Late Filing of Reports

Section 95309 is added to specify that the Department will assess a fine when a hospital fails to file a report by an established due date.

Subdivision (a) specifies that if a hospital fails to submit a required report by a due date, without an approved extension of a due date, the Department may assess a fine of one hundred dollars ($100) per day for each day that a report is not filed. Such fines are authorized by HSC Section 127374, subdivision (a).

Subdivision (b) specifies that if a hospital's equity report is 120 days delinquent, the Department shall, on an annual basis, assess the maximum fine for failure to submit a required report for a report period. HSC Section 127374, subdivision (a) establishes a maximum fine of no more than a five thousand dollar ($5,000) per year for failure to file a required report. This proposed regulation implements the statutory language by establishing a consistent process for assessing fines.

§ 95310. Fine Assessment

Section 95310 is added to clarify how hospitals will be notified when fines have been accrued, and how the fine amount will be calculated.

Subdivision (a) specifies that the Department will inform a hospital of an accrued fine upon submission of a report after a due date. The Department will calculate the fine pursuant to Section 95309, subdivision (a) and inform a hospital's designated contact person(s) via email of the accrued fine. This provision implements HSC Section 127374, subdivision (a) by establishing a consistent process for assessing fines and providing notice of the accrued fines.

Subdivision (b) specifies that the Department will inform a hospital of an accrued fine upon a hospital's extension request and its approval after a due date. The Department will calculate the fine pursuant to Section 95309, subdivision (a) and inform a hospital's designated contact person(s) via email of the accrued fine. This provision implements HSC Section 127374, subdivision (a) and is necessary to establish a consistent process for assessing fines and providing notice of accrued fines for delinquent days between a due date and an approved extension request.

Subdivision (c) specifies that the Department will calculate the accrued fine pursuant to Section 95309. Hospitals may accrue a fine of one hundred dollars ($100) per day for late submission of report as described in subdivision (a) and by late extension approval as described in subdivision (b); and may not exceed five thousand dollars ($5,000) pursuant to HSC Section 127374, subdivision (a). This is necessary for transparency to specify the maximum fine amount and rate at which fines may be imposed on a hospital due to late submission and late extension approval.

§ 95311. Filing an Appeal

Section 95311 is added to specify the requirements for a hospital that has received a notice of an accrued fine to file an appeal.

Subdivision (a) is added to specify that a hospital that has received a notice of an accrued fine may appeal the fine assessment by requesting a hearing, and that the request must be filed with the Department's Hearing Officer in writing no later than 30 days from the date on the notice. This provision is necessary to establish a consistent process and specific timeframe for initiating appeals.

Subdivision (b)(1) through (b)(5) specify the information required to be included on the written request. The required information is necessary to identify the hospital filing the appeal and the matters being appealed.

§ 95312. Hearing Officer Contact Information

Section 95312 is added to provide contact information for the Department's Hearing Officer. This is necessary as appeals and other documents must be filed with the Hearing Officer.

Subdivisions (a) and (b) specify that hearing requests and other communications shall be sent to the Hearing Officer by either mail to the Department's Legal Office in Sacramento or by email to HearingOfficer@hcai.ca.gov.

§ 95313. Prehearing Provisions

Section 95313 is added to specify the prehearing provisions for all parties.

Subdivision (a) specifies that the hospital and the Department will be notified of the hearing date and time at least 30 calendar days in advance. This provides parties the time necessary to prepare hearing exhibits and to make other request or arrangements for the hearing.

Subdivision (b) specifies that the hospital and the Department shall provide copies of proposed exhibits to the Hearing Officer and to the other party no later than 10 calendar days prior to the hearing. This is necessary to provide time for parties and the Hearing Officer for review.

Subdivisions (c) through (g) clarify that parties may make certain requests prior to the scheduled hearing: change of hearing date, change of hearing method, consolidate matters for hearing, and request an interpreter or a court reporter. Many of these subdivisions also specify that requests shall be submitted within specific timeframes prior to the scheduled hearing, which is necessary to review requests.

§ 95314. Conduct of Hearing

Section 95314 is added to clarify the procedures by which the hearing will be conducted to ensure hearings are fair and consistent.

Subdivisions (a) through (f) specify who will conduct the hearing, the method of conducting the hearing, the standards for admission of evidence and testimony at the hearing, the means of recording the hearing, and that the hearing will be open to the public. These procedures are necessary to provide for a fair hearing consistent with established standards for administrative proceedings.

§ 95315. Settlement

Section 95315 is added to clarify that if a settlement of the appeal is reached between the hospital and the Department before the hearing, the hearing will be canceled. This is necessary because it allows the Department and the hospital to settle an appeal prior to

the scheduled 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.

§ 95316. Decision

Section 95316 is added to define and provide notice of the process for adoption of a hearing decision by the Director of the Department.

Subdivision (a) states that the Department may reduce or waive the fine due to good cause after assessment of evidence and documentation provided by the parties. This is necessary to allow for other factors that the hospital may present on their behalf to support the waiver or reduction of the accrued fine.

Subdivision (b) states that the Hearing Officer shall prepare a recommendation of decision for the Director of the Department. The recommended decision shall be presented in writing and include findings of fact and conclusions of law. This is necessary to provide the Director with the required information to make a final determination and uses standard terms of art in administrative hearings, which need no further definition.

Subdivision (c) states that 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 that the Director makes the final determination regarding the appeal based only on the hearing record and not on any external information that would not have been provided during the hearing to the Hearing Officer.

Subdivision (d) 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.

VI. ECONOMIC IMPACT ANALYSIS

New regulations are required to implement the Act. HCAI has narrowly tailored the proposed regulations to implement the hospital equity measures reporting requirements. The proposed regulations impose only minor additional reporting or other requirements on any businesses, organizations, or individuals.

The proposed regulations specify the standardization of reporting requirements for structural and quality measures, standardizing key definitions and stratification

categories, clarifying hospital and hospital system contact information and registration, and establishing firm timetables for deliverables. Furthermore, the regulations define the process for report submission, extension requests, and appeal procedures regarding fines related to non-submission of reports.

Therefore, the Department concludes that:

(1) This regulatory action will not create jobs within the state.
(2) This regulatory action will not eliminate jobs within the state.
(3) This regulatory action will not create new businesses.
(4) This regulatory action will not eliminate existing businesses.
(5) This regulatory action will not expand businesses currently doing business within the state.
(6) This regulatory action will not impact workers' safety.
(7) This regulatory action will not impact the state's environment.
(8) This regulatory action will not result in any change to housing costs.

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

The Department has determined that adoption of the proposed regulations would not have an adverse economic impact on any business in the State of California because the regulations do not add any additional reporting requirements or other burdens to the existing statutorily mandated programs.

VIII. TECHNICAL, THEORETICAL, OR EMPIRICAL STUDY, REPORTS, OR SIMILAR DOCUMENT RELIED UPON

The measures hospitals are required to report were selected based on recommendations from HEMAC. Additional information from hospital workshopping, stakeholder input, HCAI legal, and HCAI analyses was used to assess these measures. Factors considered include hospitals' data collection and analysis capacity, data completeness, de-identification and small numbers, stratification, standardization, validation, and the ability of the measures to inform action.

Structural Measures

1. The three structural measures based on The Joint Commission's R3 Report: Requirement, Rational, Reference:

a. Designate an individual to lead hospital health equity activities.
b. Provide documentation of policy prohibiting discrimination.
c. Report percentage of patients by preferred language spoken.

2. Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure.

3. CMS Screening for Social Drivers of Health and CMS Screen Positive Rate for Social Drivers of Health and intervention.

The three structural measures based on The Joint Commission's R3 Report: Requirement, Rational, Reference. The structure measures of CMS HCHE Measure, CMS Screening for Social Drivers of Health, and CMS Screen Positive Rate for Social Drivers of Health and intervention measures were defined by the CMS.

The Joint Commission's R3 Report: Requirement, Rational, Reference: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

CMS HCHE: https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

CMS Screening for Social Drivers of Health and CMS Screen Positive Rate for Social Drivers of Health and Intervention: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Core Quality Measures for General Acute Hospitals

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Would recommend hospital.
2. HCAHPS survey: Received information and education.
3. Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate.
4. AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications.
5. California Maternal Quality Care Collaborative (CMQCC) Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate.
6. CMQCC Vaginal Birth After Cesarean (VBAC) Rate.
7. CMQCC Exclusive Breast Milk Feeding.
8. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate.
9. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis.

HCAHPS Fact Sheet: https://www.hcahpsonline.org/globalassets/hcahps/facts/hcahps_fact_sheet_april_2022.pdf

The AHRQ Quality Indicators Empirical Methods, v2023: https://qualityindicators.ahrq.gov/Downloads/Resources/Publications/2023/Empirical_Methods_2023.pdf

The HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate:
https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california

Let's Get Healthy California Redesigning the Health System / Reducing Hospital Readmissions:
https://letsgethealthy.ca.gov/goals/redesigning-the-health-system/reducing-hospital-readmissions/

CMS Readmission Measures Methodology:
https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans:
https://www.cmqcc.org/system/files/Vbirth-Toolkit-with-Supplement_Final_11.30.22.pdf

Ways Forward in Preventing Severe Maternal Morbidity and Maternal Health Inequities: Conceptual Frameworks, Definitions, and Data, from a Population Health Perspective:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9351612/

Core Quality Measures for Children's Hospitals

1. Pediatric experience survey with scores of willingness to recommend the hospital.
2. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate.

The pediatric experience survey with scores of willingness to recommend the hospital measure was derived from the HCAHPS survey but modified to accommodate the data collection practices already in place at children's hospitals.

The HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate:
https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california

Let's Get Healthy California Redesigning the Health System / Reducing Hospital Readmissions:
https://letsgethealthy.ca.gov/goals/redesigning-the-health-system/reducing-hospital-readmissions/

CMS Readmission Measures Methodology:
https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

Core Quality Measures for Acute Psychiatric Hospitals

1. HCAHPS survey: Would recommend hospital.
2. HCAHPS survey: Received information and education.

3. Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate.
4. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, Stratified by Behavioral Health Diagnosis.
5. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate in an Inpatient Psychiatric Facility (IPF).
6. CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) program Screening for Metabolic Disorders.
7. The Joint Commission National Quality Measures: Substance Use Measures (SUB) SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge.

HCAHPS Fact Sheet:
https://www.hcahpsonline.org/globalassets/hcahps/facts/hcahps_fact_sheet_april_2022.pdf

The AHRQ Quality Indicators Empirical Methods, v2023:
https://qualityindicators.ahrq.gov/Downloads/Resources/Publications/2023/Empirical_Methods_2023.pdf

The HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate:
https://data.chhs.ca.gov/dataset/all-cause-unplanned-30-day-hospital-readmission-rate-california

Let's Get Healthy California Redesigning the Health System / Reducing Hospital Readmissions:
https://letsgethealthy.ca.gov/goals/redesigning-the-health-system/reducing-hospital-readmissions/

CMS Readmission Measures Methodology:
https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

CMS Inpatient Psychiatric Facility Specifications Manuals:
https://www.qualityreportingcenter.com/globalassets/2021/05/iqr/ipfqr_programmanualv7.0_final508.pdf

The Joint Commission National Quality Measures:
https://manual.jointcommission.org/releases/TJC2020A1/MIF0221.html

Stratifications

a. Race/Ethnicity
b. Age

c. Sex Assigned at Birth
d. Expected Payor
e. Preferred Language
f. Disability Status
g. Sexual Orientation
h. Gender Identity
I. Behavioral Health Diagnosis (Additional stratification for HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate only)

United States Core Data for Interoperability (USCDI): https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v4

Behavioral Health Diagnosis stratifications for All-Cause Unplanned 30-Day Hospital Readmission Rate: https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/

IX. CONSIDERATION OF REASONABLE ALTERNATIVES

No reasonable alternatives have been identified by the Department or have otherwise been identified and brought to its attention that would be more effective in carrying out the purpose for which the action is proposed, that would be as effective and less burdensome to affected private persons than the proposed action, or that would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.