

Item #6: Assembly Bill 1204

First Year Reporting: The Hospital Experience

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Year One of Equity Reporting: What Hospitals Actually Experienced

An Empirical Account of Year One Implementation across California's
Diverse Hospitals

Summary of Findings & California's Hospitals

What We Learned from Supporting Nearly 300 Hospitals

Supporting hospitals during California's first reporting cycle revealed three practical questions for improving the program

1 Which hospitals could realistically produce meaningful equity reports?

How did hospital size, patient population, and care services influence what could ultimately be reported and displayed?

2 Which measures produced useful information?

Which measures generated disparity findings—and which produced mostly blank or suppressed results?

3 What did Year 1 reveal about improving the AB 1204 program?

How can California preserve transparency while increasing the usefulness, comparability, and fairness of future reporting?

Year 1 demonstrated that statewide equity reporting is feasible. The next step is ensuring the reports are consistently useful across California's diverse hospitals.

California's Hospital Landscape Is Diverse

456 facilities across three hospital types: Very different missions, data, patient populations, and reporting experience



General Acute
Care Hospitals

403

- GAC Discharges/year:
 - Range: 19–46,207
 - Median: 8,429
 - ~25% < 2,000
 - ~40% < 5,000
- Largest 80 GACs account for half of statewide inpatient discharges
- 134 GACs serve specialized or low-volume missions — rehab, LTACH, specialty, rural, CAH, or district
- **395 GACs submitted Year 1 reports**



Acute Psychiatric
Hospitals

40

- APH Discharges/year:
 - Range: 182–6,981
 - Median: 2,618
- 55% APHs are investor-owned
- Few APHs have EHRs: HITECH funding largely excluded APHs
- Only 7 APHs reported data for both HCAHPS items (PIX began 2026)
- Only 5 APHs reported >0 pneumonia cases; 2 >0 deaths
- **40 APHs submitted Year 1 reports**



Children's
Hospitals

13

- CH Discharges/year:
 - Range: 17–19,050
 - Median: 10,080
- 3 CHs < 250 discharges/year
- Pediatric patient population and equity measures distinct from GAC
- 10 CHs reported Pediatric Experience equity data; all 13 reported Readmission
- **13 CHs submitted Year 1 reports**

The Same Requirements — 3 Very Different Experiences

The same reporting requirements produced very different reporting experiences depending on GAC hospital size



Small Hospital

≤3,500 inpatient discharges/yr
Median ~1,139 · ~62 licensed beds

Who they are: Often the only hospital in the county. 52 rural, 38 critical access, 29 district. Median 62 beds.

Data pipeline: Most rely on 1–2-person quality departments already running CMS reporting. No dedicated analytics staff.

Pneumonia IQI: Numerator often zero, blank, or suppressed. Among numeric reporters, median ~1 death/year.

NTSV/VBAC/BF: ~22% birthing hospitals. Three measures largely inapplicable.

Data fill rate: 8.2% of stratified cells contained any reportable number. 14.9% suppressed by DDG. 76.9% still blank.

Usable equity signal: ~69% had readmission data by race. Older > younger readmits.



Medium Hospital

3,501–13,000 inpatient discharges/yr
Median ~8,429 · ~168 licensed beds

Who they are: Community hospitals serving regional populations. 9 rural, 7 district. More resources than small, fewer than large.

Data pipeline: Typically, 2–5-person quality departments. Some analytics capability, but AB 1204 required new workflows.

Pneumonia IQI: Median ~19 deaths per year. After splitting across race groups, most cells were blank or suppressed; ~54% had any race-stratified numeric data.

NTSV/VBAC/BF: ~61% birthing hospitals. Maternal measures often limited by service mix and DDG suppression.

Data fill rate: 6.7% of stratified cells contained any reportable number. 23.3% suppressed by DDG. 70.0% still blank.

Usable equity signal: ~89% had readmission data by race. Older > younger readmits.



Large Hospital

≥13,001 inpatient discharges/yr
Median ~19,440 · ~326 licensed beds

Who they are: Major regional and academic medical centers. Dedicated analytics teams. Largest GAC = 46,207 inpatient discharges.

Data pipeline: Most had existing quality data infrastructure. AB 1204 was still a significant new programming effort.

Pneumonia IQI: Median ~31 deaths per year. ~76% had race-stratified data — best of the three groups, still not universal.

NTSV/VBAC/BF: ~72% birthing hospitals. Maternal measures still limited by service mix and DDG.

Data fill rate: 9.5% of stratified cells contained any reportable number. 23.9% suppressed by DDG. 66.6% still blank.

Usable equity signal: ~91% had readmission data by race. Older > younger readmits.

Hospital Equity Reporting Program: Findings and Lessons Learned

Different Hospital Types Needed Different Measures

Separate measure sets recognized important differences across hospital types—but Year One revealed where additional refinement was needed

Measure	GAC	APH	Children's	Issue/Notes
HCAHPS Received Info & Recommend Hosp (Q17/Q19)	✓	✓	✗	Patient-experience instability: APHs had limited HCAHPS data; PIX does not map directly, 2025 HCAHPS renumbering requires HCAI clarification
AHRQ Pneumonia Mortality (IQI-20)	✓	✓	✗	APH data uncommon: only 11 had pneumonia mortality data; only 5 had >0 cases; only 2 had >0 deaths
AHRQ Surgical Death (PSI-04)	✓	✗	✗	GAC-only; overall data often reported, but stratified equity yield was limited by small denominators and suppression
CMQCC NTSV / VBAC / Exclusive Breastfeeding	✓	✗	✗	L&D-specific: 196 of 403 GACs did not provide obstetric services in CY 2024; non-birthing GACs increase in Year Two
30-Day All-Cause Readmission	✓	✓	✓	Best structural fit: broad applicability across all hospital types and sizes
30-Day All-Cause Readmission × Behavioral Health Diagnosis	✓	✓	✗	Same broad measure, but double stratification created major sparsity: 4 BH categories × all other strata = 188 additional cells
SUD Tx/Px (SUB-3/3a) & Metabolic Screening (SMD)	✗	✓	✗	APH-specific and clinically relevant, but often manual or outside existing structured reporting workflows
Pediatric Experience Survey	✗	✗	✓	Children's-specific; better measure fit, but small statewide <i>N</i> limited stratified equity yield

Hospitals Had to Build a New Reporting Program

Implementation quality depends on implementation time — and Year One gave hospitals very little time

YEAR 1 — CY2024 Data → Sept 30, 2025

- Jun 28, 2024**
Proposed regs published — public comment opens
- Aug 13, 2024**
Comment period closes.
- Dec 19, 2024**
Submitted to OAL — then withdrawn after OAL request
- Jun 4, 2025**
Final regulations approved
- Sept 30, 2025**
Reports due — ~4 months after final regulations

YEAR 2 — CY2025 Data → Sept 30, 2026

- Jan 1, 2025**
CY2025 data collection begins — under Year 1 regs
- Feb 20, 2026**
Revised proposed regulations published — comment period
- Apr 7, 2026**
Comment period closes
- Apr 28, 2026**
HCAI issues modifications — 15-day comment period
- May 13, 2026**
Latest comment period closes
- Late June 2026**
Final 2026 revisions not yet posted
- Sept 30, 2026**
Reports due — deadline unchanged

The First Year Required New Analytic Capabilities

Hospitals had to combine multiple data sources, apply new methodologies, and produce hundreds of stratified results



GAC Report Fields

2,004

**Report fields requiring
calculation, validation, &
submission**

Measures × stratifications × numerators,
denominators, and rates



New Methodologies

9

**Core quality measures across
multiple measurement
frameworks**

Each with unique technical specifications,
stratifications, and calculation methods



Specialized Analytics

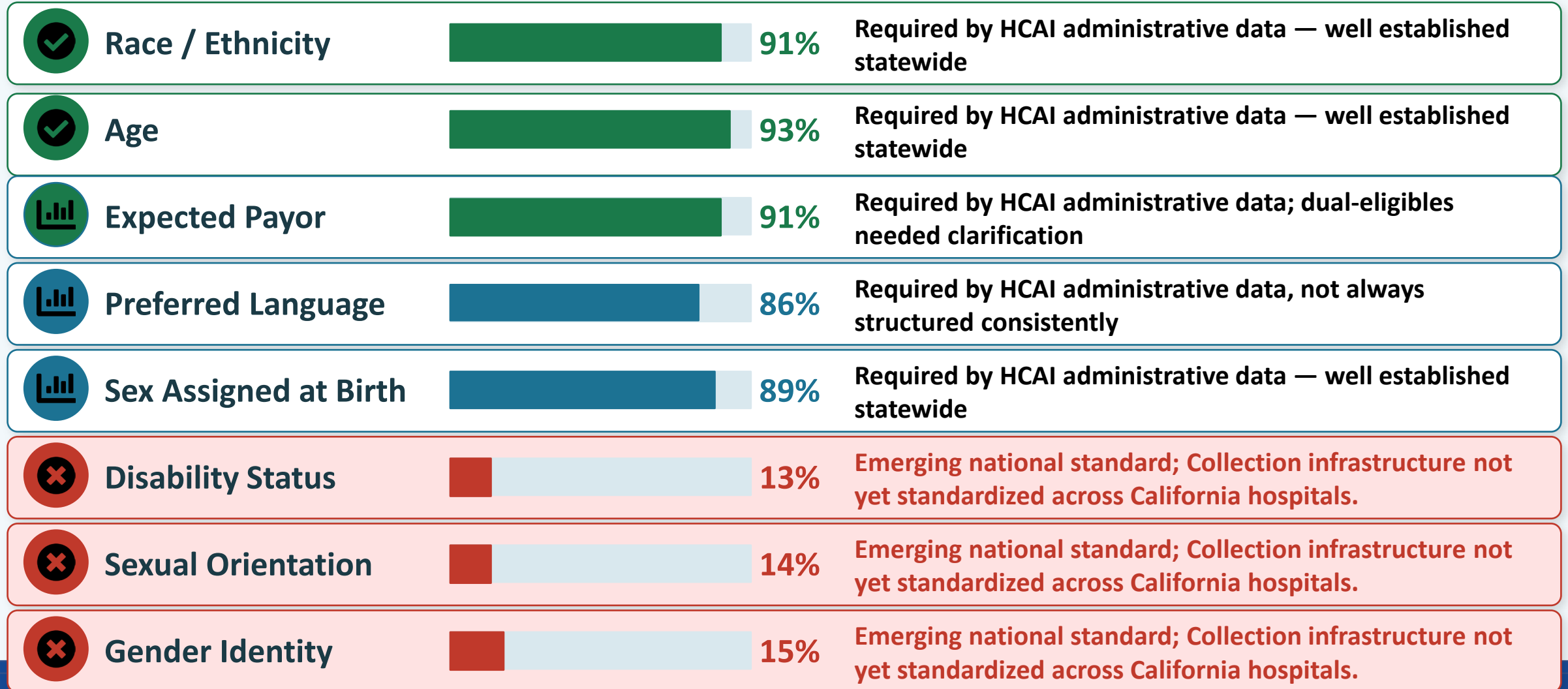
4+

**External specifications
& analytic systems**

Readmissions, behavioral health groupings,
privacy suppression, and rate-ratio calcs

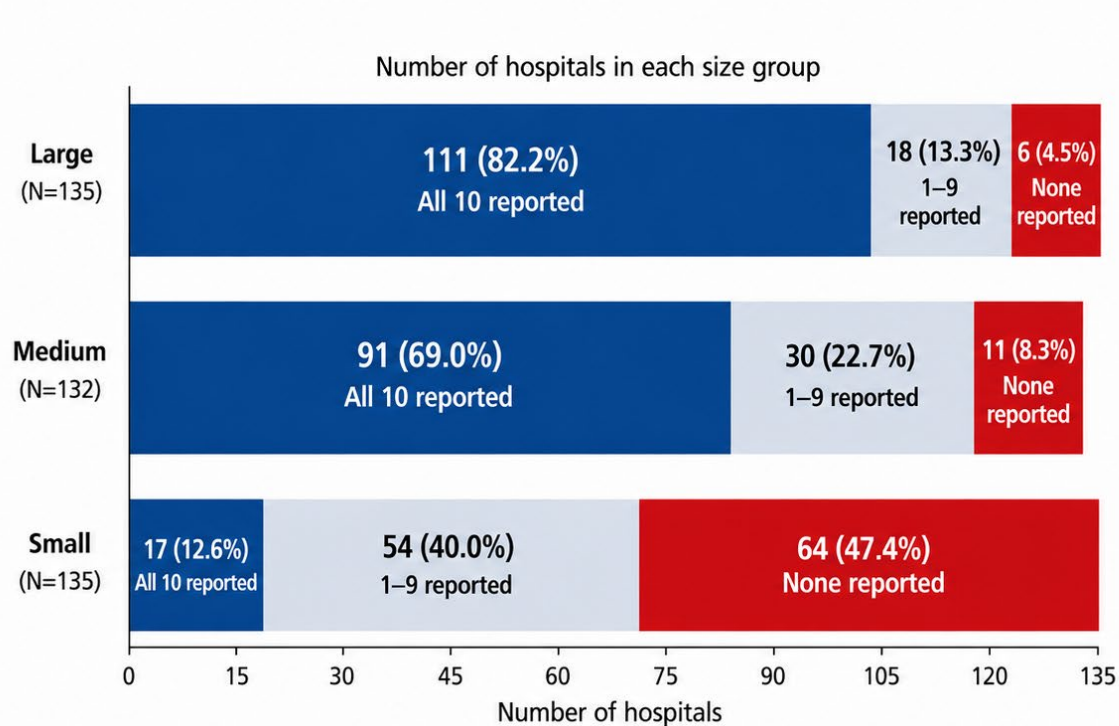
Stratifications Not Included in Existing Data

Three required equity stratifications were not part of California's standardized hospital administrative data collection infrastructure



Hospital Size Strongly Influenced the Ability to Identify Reportable Disparities

Top 10 disparity yield increased sharply with hospital volume



■ Reported all 10 Top 10 disparities
■ Reported 1–9 Top 10 disparities
■ Reported no Top 10 disparities

111/135

large hospitals reported
all 10 disparities

91/132

medium hospitals reported
all 10 disparities

17/135

small hospitals reported
all 10 disparities

■ **82.2% of large hospitals
reported all 10 disparities**

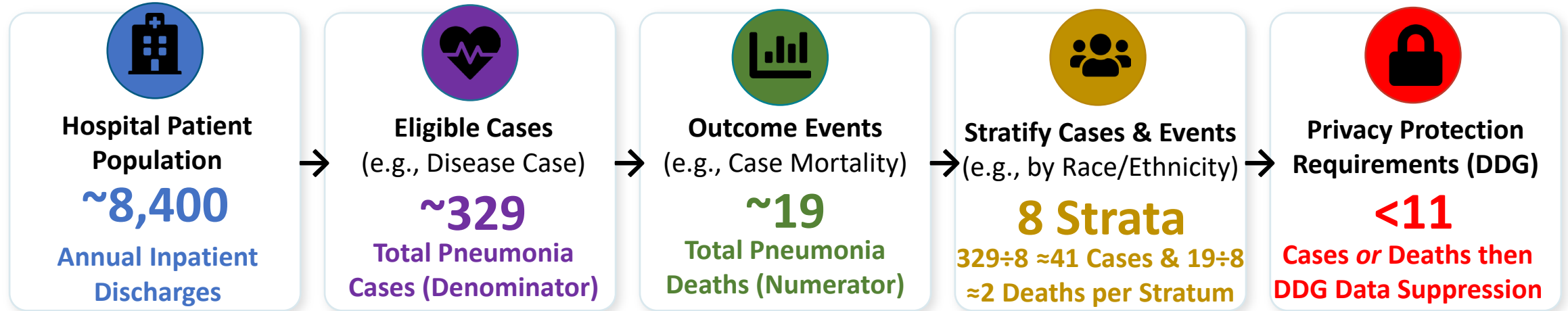
■ **69.0% of medium hospitals
reported all 10 disparities
— but nearly one-third still
had incomplete lists**

■ **47.4% of small hospitals
reported no disparities**

**Year One showed that the ability to identify reportable
disparities depended heavily on inpatient volume.**

Why Most Stratified Results Were Blank or Suppressed

Producing meaningful equity measures requires enough patients and outcome events in each stratification category to survive statistical and privacy (DDG) requirements



DDG data suppression risk if numerator <11 or denominator <20,000

GAC HOSPITALS BY INPATIENT VOLUME (Year One)

	Small	Medium	Large
Displayed	8.2%	6.7%	9.5%
Suppressed	14.9%	23.3%	23.9%
Blank / Missing	76.9%	70.0%	66.6%

Limiting factor was
subgroup volume.

Patterns from Year One Reporting

Readmission dominated Year One because it had sufficiently large numerator and denominator counts to survive stratification and DDG suppression requirements

~80% of Year One Top 10 disparities involved readmission-related measures

What Year One was able to demonstrate:

Statewide Readmission Rate by Age (Year One):

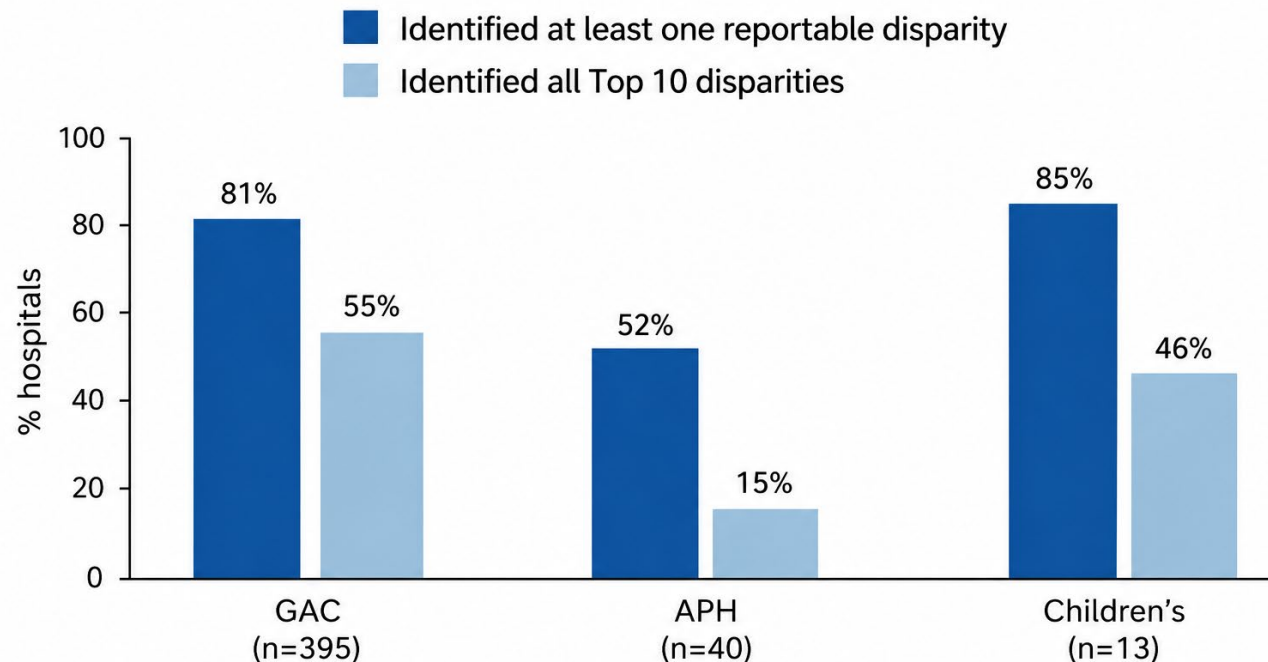


- Readmission disparities were the most consistently reportable findings.
- Readmission rates were higher in older adult groups.
- Medicare patients generally had higher readmission rates.
- Black patients often had higher readmission rates.
- Male patients often had slightly higher readmission rates.
- SOGI & disability: limited statewide reportability.
- APH pneumonia mortality: too few events for meaningful reporting.

Reporting Experiences Differed Across the Hospital Types

Year One reinforced the value of hospital-specific measure sets while identifying opportunities for further refinement

Different Hospital Types Had Different Reporting Realities



- APH measures need further refinement to better match psychiatric practice and patient volumes.
- Children's hospitals demonstrated that a distinct measure set can work when aligned with the patient population.
- Comparisons should be made within hospital types—not across fundamentally different hospitals.
- Hospital type should remain a primary consideration when refining future measure sets.

Year One supports refining measures within hospital type — not moving toward a one-size-fits-all reporting model.

Which Equity Measures Produced Useful Information?

In Year One, some measures consistently produced usable equity information, but others rarely did

 High Reporting Utility
  Moderate Reporting Utility
  Low Reporting Utility
  Not Applicable

Measure	GAC Small	GAC Medium	GAC Large	APH	Children's	Assessment
30-Day All-Cause Readmission (HCAI)						High reporting utility for all hospital types and sizes
30-Day All-Cause Readmission × Behavioral Health Diagnosis (HCAI)						High utility for Large GAC & APH; Often duplicative of prior measure
HCAHPS Received Information/Education (Q17)						High utility for Med/Large GAC; Low for APH (PIX, not HCAHPS for APH)
HCAHPS Would Recommend Hospital (Q19)						High utility for Med/Large GAC; Low for APH (PIX, not HCAHPS for APH)
AHRQ Pneumonia Mortality (IQI-20)						High reporting utility for Med/Large GAC; Low for APH
AHRQ Surgical Death (PSI-04)						High reporting utility for Large GAC; Low for Small/Med GAC
CMQCC NTSV / VBAC / Exclusive Breastfeeding						L&D-specific; High utility for Large GAC; Low utility for Small GAC
Alcohol/Drug Treatment Offered/Provided (SUB-3/SUB-3a)						APH-specific; Moderate reporting utility
CMS Screening Metabolic Disorders (SMD)						APH-specific; Moderate reporting utility
Pediatric Experience Survey						Children's hospital-specific; High reporting utility

What Year One Suggests for Future Reporting

1 Estimate reportable yield before adopting measures

Estimate displayed, suppressed, and blank stratified cells by hospital type and size.

2 Prioritize high-utility measures

Favor measures that produce interpretable subgroup rates across many hospitals.

3 Match measures to hospital populations

Continue tailoring measures to hospital types and patient populations.

4 Continue strengthening statewide data collection

Keep disability and SOGI as equity goals but distinguish data maturity from performance measurement.

5 Provide stable specifications earlier

Finalize specifications, rate logic, DDG examples, and portal validation with time for hospital review.

6 Explain blanks and suppression

Explain blanks, suppression, and why some subgroup results cannot be displayed.

Bottom line: California demonstrated that statewide hospital equity reporting is feasible. Year One also provided the evidence needed to make future reporting more useful, more interpretable, and more sustainable.

Questions?

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