HEALTH AND SAFETY CODE - HSC

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION [127000 - 130079] *(Heading of Division 107 amended by Stats. 2021, Ch. 143, Sec. 28.)*

PART 2. HEALTH POLICY AND PLANNING [127280 - 127697] *(Part 2 added by Stats. 1995, Ch. 415, Sec. 9.)*

CHAPTER 2. Health Policy Research and Evaluation [127340 - 127376] *(Chapter 2 heading added by Stats. 1995, Ch. 415, Sec. 9.)*

ARTICLE 3. The Medical Equity Disclosure Act [127370 - 127376] *(Article 3 added by Stats. 2021, Ch. 751, Sec. 2.)*

127370. The Legislature finds and declares all of the following:

(a) The COVID-19 health emergency has thrown into sharp relief longstanding health inequities along racial, ethnic, and socioeconomic lines. Black, Hispanic, and Indigenous people have been disproportionately affected during the pandemic; for example, the age-adjusted mortality rate among Black people with COVID-19 is more than three times as high as that of Whites.

(b) Disparities in access to care and quality of care contribute to racial health disparities. The disparate impact of the pandemic has highlighted the tiered nature of the current health care system, a structure that significantly impacts the quality of care patients receive along racial, ethnic, and socioeconomic lines.

(c) Reporting on the racially disproportionate impact of COVID-19 has called attention to the need for further data on racial and ethnic disparities in health care.

(d) Data currently reported by California hospitals that could be used to analyze access to and quality of care by age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and socioeconomic status is not available to consumers or the general public.

(e) Although nonprofit hospitals are currently required to develop and report on their community benefits plans to provide services to vulnerable populations in their service areas, the law should be updated to ensure that the needs of vulnerable populations, including racial and ethnic groups experiencing disparate health outcomes and socially disadvantaged groups, are specifically considered and addressed.

(f) All California health systems and large physician providers, whether operated as nonprofit or for-profit, and by a county, the University of California, or other governmental entity, should systematically collect and publish racial and ethnic data for a range of standard access, quality, and outcome measures, as well as their processes to overcome biases in the provision of and access to health care services.

(g) As part of President Joe Biden’s January 2021 Executive Order Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, the federal Centers for Medicare and Medicaid Services are developing health equity measures as part of the proposed rules for other Medicare prospective payment systems, which may include stratification of quality measure results by race, ethnicity, dual eligible status, disability status, LGBTQ+ identity, and socioeconomic status and a standardized set of demographic data elements by hospital at the time of admission.

(h) The Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) are standardized, evidence-based measures of health care access and quality that are readily used with hospital inpatient administrative data for all payor categories to measure and track clinical performance and outcomes. The four areas for which AHRQ has developed indicators focus on adult prevention, pediatric prevention, inpatient quality, and patient safety. The state has used these indicators in the past to explore racial and ethnic disparities at an aggregate level.

(i) The dearth of racially and ethnically disaggregated data reflecting the health of communities of color underlies the challenges of a fully informed public health response, and is a matter of statewide concern. It will benefit the state’s public health response for hospitals and health systems to share information with the state, consumers, and the public using the standardized AHRQ QIs and NCQA HEDIS measures, as it will facilitate input by affected communities into addressing longstanding racial, ethnic, and socioeconomic health disparities, and thereby contribute to well-informed health policy.

(j) Facilitating the public sharing of data on health care disparities will assist the state and civil rights advocates in enforcing existing civil rights laws, including Section 11135 of the Government Code, the Unruh Civil Rights Act (Section 51 of the Civil Code), Title VI of the Civil Rights Act of 1964 (Public Law 88-352), and Section 1557 of the Patient Protection and Affordable Care Act (Public Law 111-148).

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127371. As used in this article:

(a) “Advisory committee” means the Health Care Equity Measures Advisory Committee established pursuant to Section 127376.

(b) “Disparity reduction” means a reduction in variation in disease occurrence, including communicable diseases and chronic conditions, as well as health outcomes for vulnerable populations.

(c) “Equity report” means a written document prepared for annual submission to the Department of Health Care Access and Information pursuant to this article.

(d) “Hospital” means an acute hospital licensed pursuant to subdivision (a), (b), or (f) of Section 1250.

(e) “Hospital system” means 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 Section 1250.

(f) “Integrated system” means an entity or system of entities that includes one or more hospitals and is related to one or more hospitals, health plans, or physician groups through parent-subsidiary relationships, contractual relationships, or common boards and shared senior management.

(g) “Patient population” means all of the people served by a hospital.

(h) “Vulnerable populations” includes 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.

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127372. (a) A hospital shall prepare an annual equity report. The equity report shall include an analysis of health status and access to care disparities for patients on the basis of age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and payor.

(b) On and after September 30, 2025, but not until 12 months after the release of the federal Centers for Medicare and Medicaid Services’ health equity quality measures for their proposed rules for other Medicare prospective payment systems, the annual equity report submitted by a hospital shall report on the Agency for Healthcare Research and Quality’s Quality Indicators or any other relevant measures specified by the advisory committee, including measures of access, quality, and outcomes by age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and payor for the hospital’s patient populations, pursuant to the recommendations provided by the advisory committee. The equity report shall also include a plan to prioritize and address disparities for vulnerable populations identified in the data, with measurable objectives and specific timeframes, pursuant to the recommendations provided by the advisory committee and consistent with subdivision (d).

(c) A hospital system with more than one hospital shall present the information in the equity report disaggregated at the individual hospital level and aggregated across all hospitals in the system.

(d) A hospital’s equity report shall include a health equity plan to achieve disparity reduction for disparities identified in the data, as specified by the advisory committee, with measurable objectives and specific timeframes for disparity reduction. This shall include

addressing both of the following:

(1) The 10 widest disparities in health care quality for vulnerable populations, access, or outcomes, as determined by the advisory committee.

(2) Performance across all of the following priority areas:

(A) Person-centered care.

(B) Patient safety.

(C) Addressing patient social determinants of health.

(D) Effective treatment.

(E) Care coordination.

(F) Access to care.

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127373. (a) A hospital shall do all of the following with respect to an equity report prepared pursuant to Section 127372:

(1) Include in the equity report an explanation of the methodology used, written in plain English.

(2) Annually submit the equity report to the Department of Health Care Access and Information. A hospital shall file a copy of the report with the department for the relevant calendar years according to the reporting schedule established by the department.

(3) Annually post the equity report on the hospital's internet website. The report shall be available via a link that includes the words "Equity Report" or a substantially similar term, which shall be visible on the main page of the hospital's internet website as loaded by a standard internet browser in an easily readable font size without having to scroll down.

(b) A hospital under the common control of a single corporation or another entity may file a consolidated equity report if the report includes each hospital's equity data.

(c) Hospitals that are part of an integrated system may prepare and submit a single joint equity report if the report separately addresses each hospital's equity analysis.

(d) Data and information included in annual equity reports shall be reported 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, including the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127374. (a) The Department of Health Care Access and Information may impose a fine not to exceed five thousand dollars ($5,000) against a hospital that fails to adopt, update, or submit an equity report consistent with this article and any implementing regulations adopted by the department.

(b) The department may grant a hospital an automatic 60-day extension to submit an equity report.

(c) The department shall annually prepare, and post on its internet website, a report that includes a list of all hospitals that failed to submit equity reports.

(d) The department shall make all equity reports submitted pursuant to this article available to the public on its internet website.

(e) Data and information posted on hospital internet websites and submitted to and made public by the department shall be disclosed in a manner that protects the personal information of patients pursuant to deidentification requirements as specified by the department, as well as any state and federal privacy laws, including the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127375. The Department of Health Care Access and Information shall adopt any rules, regulations, or informal guidance necessary to further the objectives of this article.

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)

127376. (a) The Department of Health Care Access and Information shall convene a Health Care Equity Measures Advisory Committee, composed of at least one academic health care quality and measurement expert and at least six stakeholder representatives, including at least one representative of each of the following:

(1) Associations representing public hospitals and health systems.

(2) Associations representing private hospitals and health systems.

(3) Organized labor.

(4) Organizations representing consumers.

(5) Organizations representing vulnerable populations.

(6) A representative of the department.

(b) (1) The advisory committee membership shall consist of no fewer than 9 persons and no more than 11 persons.

(2) The Director of the Department of Health Care Access and Information shall appoint the advisory committee members pursuant to subdivision (a). The initial terms of the committee members shall be established to create staggered terms of office by drawing lots at the first meeting of the committee. One-half of the committee members shall serve a two-year term, and one-half of the committee members shall serve a one-year term. After their initial term of office is complete, a committee member shall serve a two-year term. Each appointed member shall serve a term of two years. Each appointed member shall serve at the discretion of the director and may be removed at any time.

(3) The chairperson of the advisory committee shall be an appointed member and shall be elected by a majority of the appointed members.

(c) (1) The advisory committee shall assist and advise the director in reviewing and amending the appropriate measures that align with the health equity measures developed by the federal Centers for Medicare and Medicaid Services at the hospital-, hospital system-, and integrated system-level related to access, quality, and outcomes, including any relevant Agency for Healthcare Research and Quality's Quality Indicators, that hospitals are required to report in their annual equity reports pursuant to Section 127372.

(2) The advisory committee shall provide recommendations pursuant to paragraph (1) no later than December 31, 2022, or 120 days after the release of the health equity measures by the federal Centers for Medicare and Medicaid Services, whichever occurs later. These recommendations shall be published on the department's internet website.

(d) (1) The advisory committee shall assist and advise the director in reviewing, amending, and evaluating, as necessary, the appropriate disparities and performance areas to be addressed in the health equity plan that a hospital is required to include in their annual equity reports pursuant to Section 127372.

(2) The advisory committee shall consider differences in patient populations and geographic areas served when reviewing health equity plans.

(3) No later than September 30, 2027, or 24 months after the release of the health equity measures by the federal Centers for Medicare and Medicaid Services, whichever occurs later, the advisory committee shall make recommendations to the department regarding the health equity plan, as described in Section 127372. These recommendations shall be published on the department's internet website.

(e) (1) The advisory committee shall, through its meetings, provide a forum for stakeholder and public engagement.

(2) The advisory committee shall meet at least twice per year or when requested by the director.

(Added by Stats. 2021, Ch. 751, Sec. 2. (AB 1204) Effective January 1, 2022.)