



August 13, 2024

Alma Lopez, Supervisor Office of Information Services
Department of Health Care Access and Information
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Dear Ms. Lopez:

Thank you for the opportunity to provide comments on the regulations to implement the Hospital Equity Measures Reporting Program, which is required by Assembly (AB) Bill 1204 (2021). California's hospitals are committed to improving the health and well-being of the communities they serve. As you know, AB 1204 requires hospitals to annually submit an equity report that includes analyses of health status and access-to-care disparities for patients on the basis of race, ethnicity, and payer, along with plans for addressing those disparities. AB 1204 also requires the Department of Health Care Access and Information (HCAI) to convene a Hospital Equity Measures Advisory Committee to help guide HCAI on how hospitals should report disparities in health care quality for vulnerable populations. On behalf of more than 400 hospitals and health systems in California, the California Hospital Association (CHA), along with those represented in this letter, is pleased to provide input and recommendations on the draft regulations.

First, we want to reiterate that the program must take a patient-centered approach, ensuring patients and their experiences with the health care system are central to its design. When experiencing an illness requiring hospital inpatient care, providers work with patients and families to identify their goals, preferences, and concerns, and help to facilitate the completion of forms and other necessary tasks. Asking patients for information that may not be obviously connected to their care or that is sensitive in nature may hinder the patient's care experience. While hospitals agree that it is vital to collect information to provide culturally competent care, it must be done in a way that engenders trust between patients and providers.

We appreciate the department's alignment with federal and state standards, such as those developed by the Office of Management and Budget, United States Core Data for Interoperability, Centers for Disease Control and Prevention, and others. However, concerns remain about elements of the draft regulations. To this end, we recommend the following:

- Phase in the program — start with a smaller set of measures and add new measures each year.

- Align with federal and national efforts by removing select measures.
- Provide standard benchmarks or reference points for hospitals to use.
- Delay implementation for acute psychiatric and exempt rehabilitation hospitals until appropriate measures are identified by the Advisory Committee and HCAI.

Overall Comments

Start with a smaller set of measures.

This is an opportunity for HCAI to accelerate the closing of gaps by requiring a narrow set of measures for hospitals to report on and develop actionable interventions specific to the vulnerable communities that each hospital serves. For general acute care hospitals, stratification of every measure would add eight additional data points to nine existing measures, resulting in the need to collect and report 72 additional measures, which depending on the patient volume, may or may not yield actionable data. In addition, the data specifications outlined in the draft regulations are different from federal and national requirements and as such, would require hospitals to consolidate data and compile reports separately. Furthermore, while these proposed requirements will be difficult for all hospitals, it will be especially challenging for California's critical access, district, and rural hospitals and will further strain the financial and staff resources of all facilities. Starting with a smaller set of measures would allow all hospitals the needed time to train staff on collecting sensitive patient information, dedicate resources necessary to perform the analytical and stratification activities necessary to comply, and identify actionable interventions. If the program maintains the number of measures in the draft regulations, it may simply become an additional reporting exercise instead of one focused on the intended outcomes of enhancing health equity.

Data collection and analysis will be challenging and require additional resources.

Collecting the required data will be challenging for hospitals and new for patients, especially given the sensitivity of select information. Staff training will need to be developed and implemented so the patient experience will be positive. In addition, there are currently no standards for the sexual orientation and disability categories, and as such, are not consistently collected. Since they are not clearly defined locally, statewide, or nationally, variations in definitions and collection of proposed categories will be prevalent. Hospitals may interpret data categories in different ways, providing the state with inconsistent data across the field. We recommend that HCAI provide clarity on these and other categories that are not currently required by federal or national agencies. Further, these categories will require hospitals to work with their vendors to build new capabilities in their electronic health records systems to collect, analyze, and compile for a hospital's report. These and other operational issues will require all hospitals to develop new processes to ensure the patient experience is positive while balancing the caregiver burden and facilities' financial resources. While this will be difficult for all hospitals, this will be especially challenging for California's critical access, district, and rural hospitals.

Adding new operational requirements will take time to implement and will require additional resources.

Data exists throughout the hospital. Applicable patient data and expertise required to collect, analyze, and compile are with multiple departments, all of which will need to be engaged to complete the report while meaningfully health disparities and enhance health equity in their hospital. Again, the program needs to take a patient-centered approach and ensure that patients and their experience with the health care delivery system are at the center of the program. As such, the training of hospital staff will take time to ensure the patient experience is positive.

To ensure compliance, hospitals will need to either redirect the work of current staff or hire additional staff, which could result in increased costs for hospitals. This will be particularly challenging for most acute psychiatric, rural, critical access, and district hospitals that have limited staff and financial resources. Moreover, compliance will be particularly challenging for all hospitals given the regulations will not be finalized until fall 2024 and collection of data must begin in January 2025.

There is a need to include common reference points across all measures for all hospitals.

The draft regulations do not include any statewide performance standards or reference points to compare data across various categories. The regulations call for hospitals to present data by comparing the performance of each stratified group against the best-performing group for each category (the rate ratio). This methodology presents several problems, including:

- The best-performing group may often be one that presents infrequently in the hospital. In this scenario, hospitals will be comparing performance for numerous samples to performance for a small subset of patients, thus inviting erroneous and statistically insignificant conclusions. Hospitals should only be required to provide data for groups that present large enough samples from which statistically valid comparisons can be drawn (see below). Though regulations do instruct hospitals to blind data consistent with the California Health and Human Services Agency's Data De-Identification Guidelines (DDG), the thresholds detailed in the DDG are designed to protect the patient's identity and were not crafted for purposes of ensuring sample groups are large enough to create meaningful comparisons.
- The current methodology implies that the best performing group within the hospital is the benchmark whose performance all other stratified groups should match. This critically misses that by the standards of national performance, the care delivered by the hospital to those outside of the best performing group may still also be exemplary. As constructed, a consumer of a hospital's equity report will have no bearing as to whether a hospital is delivering quality care to all populations, but instead will only understand the distance between stratified groups. Instead of requiring hospitals to compare performance against the best-performing group within the hospital, the regulations should instead use national medians for the performance of each group, for each measure as the reference point.
- Another alternative is for HCAI to choose the largest stratification category as the reference category for each stratification variable based on a statewide analysis of the distribution of the categories. For example, English for Preferred Language, Non-Disabled for Disability Status

would be assigned as the common referents that are used in all equity reports, which would ensure that comparisons across equity reports could be made and would provide precision and statistical power for comparing the rate ratios.

There is a need to include significance thresholds to ensure data stratification is reliable and valid.

In addition to being time and resource-intensive, stratification of data will not be reliable or valid if the number of patients in any given category is too small and does not result in statistically significant outcomes. We recommend that HCAI set minimum volume thresholds separate from the DDG for both quality measures and each of the stratification categories. Below these thresholds, hospitals should be expected to blind the data for these groups and measures and refrain from including this information in final reports.

Need for additional technical specifications.

Whereas the draft regulations have a detailed guidance template including file layout, naming conventions, formats, and other specifications for an individual hospital, there is no such guidance template for the *system* reports, which will be more complicated. We recommend creating a similar guidance document. In addition, Attachment A provides recommendations and clarifying questions on the technical specifications of measures.

There is a need to provide opt-out options due to sensitive information and compliance requirements of the California Data Exchange Framework (DxF).

We appreciate that the proposed regulations on reporting different data elements would need to be de-identified. While we appreciate that hospitals will only be required to include the numerators and denominators in their reports, it is important to note that once the data is documented and reported, the DxF requires hospitals to send electronic information to intermediaries, such as qualified health information organizations, and other DxF participants. Some patients may not want hospitals to collect data on sensitive information, such as sexual orientation or disability status. At a minimum, we propose allowing hospitals to add “Patient declined to answer” for all these data elements and that the response allows hospitals to drop these data points from the reported denominator.

Comments on Specific Measures

The following are comments on specific proposed measures:

- PSI-04 Death Among Surgical Inpatients with Serious Treatable Complications Core Measure for General Acute Care Hospitals: This measure will be removed from the CMS Inpatient Quality Reporting Program (IQR) beginning with the FY 2027 payment determination (July 2023–June 2025 data) and replaced with a more broadly applicable 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure. Given this, we recommend HCAI forgo inclusion of PSI-04 as an acute hospital core measure.

- HCAHPS — first, the HCAHPS survey is changing in 2025, making 2024 benchmarks invalid for future years. In addition, CMS has recommended that HCAHPS be put on hold for the value-based payment programs to allow for new benchmarks to be set. We would encourage HCAI to mirror CMS' actions. Furthermore, they are unavailable for acute psychiatric, rehabilitation, and critical access hospitals.
- AHRQ Quality Indicator 20 (IQI 20) Pneumonia Mortality Rate Core Measure for Acute Psychiatric Hospitals — AHRQ PSI measures are not currently calculated or required for acute psychiatric hospitals. Inpatient quality program (IQR) participation is required for general acute care hospitals *only*, so these data are unavailable for critical access, psychiatric, children's, rehabilitation, and long-term care, and cancer hospitals. It would be an undue burden to implement a process to calculate this measure just for the equity report.

Additional clarifying questions and concerns about specific measures are outlined in Attachment B.

Comments for Children's Hospitals

We support the two proposed children's hospital-specific core quality measures:

- The Child Hospital Survey, specifically the question on Willingness to Recommend
- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

We also appreciate the acknowledgement that different children's hospitals use different patient experience surveys. This measure, as proposed, will allow their health equity scores to be compared without disrupting their existing quality improvement programs and contracting arrangements. We also appreciate the change to all-cause, 30-day *unplanned* readmission rate, as children's hospitals tend to have much higher planned readmission rates than the average community hospital, and for good reason. A large proportion of readmissions at children's hospitals are for inpatient rehabilitation and chemotherapy, and thus do not represent a quality-of-care failure.

Comments for Acute Psychiatric Facilities

Delay compliance until 2026 for acute psychiatric hospitals.

As previously noted, compliance with these requirements will require dedicated resources, staff training, and time. However, for acute psychiatric facilities, there are specific issues and challenges. First, while we appreciate the overall alignment with measures already reported, CMS has delayed the structural measures requirement for acute psychiatric hospitals. It is important to note that acute psychiatric facilities were not eligible for federal Health Information Technology for Economic and Clinical Health Act (HITECH) funding, which supported the implementation of electronic health records systems for general acute care hospitals. As such, for many acute psychiatric facilities, collecting, analyzing, and stratifying data outlined in HCAI's draft will be a labor-intensive, manual process. As such, we recommend a delay in reporting for these facilities and to align with the federal timeline.

Exempt acute psychiatric facilities from reporting HCAHPS measures.

Acute psychiatric facilities do not and are not required to administer the HCAHPS survey. As such, requiring this hospital type to report this measure will result in increased financial and staff costs as this will be a whole new set of measures that these hospitals do not currently collect.

Comments for Rehabilitation Hospitals and Long-Term Acute Care Hospitals

Exempt rehabilitation and long-term acute care hospitals from compliance.

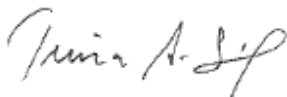
Hospitals that exclusively provide extended hospital care to patients with complex medical and rehabilitative needs, such as hospitals currently federally certified as long-term acute care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs) should be exempted from the data reporting requirement. Both of these facility types deliver post-acute care services and treat patients following their acute hospitalization for a disabling illness or injury. However, both hospital types are licensed as general acute care hospitals in California and as such, fall under the definition in the AB 1204 statute. However, none of the measures in the draft regulations apply to either hospital type. In addition, the advisory committee has not discussed measures specific to these hospital types. As such, we recommend that the regulations specify that these hospitals are not required to comply with the Hospital Equity Measures Reporting Program at this time.

Conclusion

California's hospitals are committed to improving the health and well-being of the communities they serve. Hospitals share the goals of the legislation and stand ready to partner with HCAI to ensure its implementation. Hospitals and health systems are also leading this work and have lived experience that will further inform this process, which we believe will be invaluable to ensuring that we are successful together.

Thank you for the opportunity to provide feedback on the draft regulations to implement the Hospital Equity Measures Reporting Program. If you have any questions, please feel free to contact me at tgonzalez@calhospital.org.

Sincerely,



Trina A. Gonzalez
Vice President, Policy

cc: Michael Valle, Chief Information Officer and Deputy Director