

Item #5: Follow-up to the last HEMAC Meeting and a Lessons Learned Framework for 2027 Considerations

Christopher Krawczyk, PhD, Chief Analytics Officer, HCAI

Background

- 2022-2023: HCAI and the Advisory Committee discussed multiple candidate measures
- 2022-2023: HCAI "workshopped" measures via stakeholder meetings and targeted outreach, hospital surveys, and data simulations
- 2022-2023: HCAI then presented these measures and "workshopped" findings at HEMAC meetings for discussion and input.
 - Considerations in forming HEMAC recommendations:
 - Completeness of data for each measure
 - Likelihood of small counts, particularly when stratified
 - Importance of a topic or a population being included in the measure set and data
 - Variation among types of hospitals (GAC, psychiatric, childrens), size of hospitals, existing data and analytic capacity,
 - Hospital burden in collecting data and doing the analytic methods
 - Raising the bar in data completeness, data quality, analytic capacity
 - Few measures were straightforward across these considerations

Background (Continued)

- 2022-2023: After open deliberation, HEMAC recommended a set of measures.
- 2024-2025: Measures were formally adopted through the regulatory process, with the understanding that initial years of data reporting would provide critical lessons learned.
- 2025-2026: The first year of data reporting has identified lessons learned for improving the program
 - Lessons learned were presented at the last HEMAC meeting. Comments and questions were received that require partnership and deliberation of solutions for the 2027 recommendations

Goal: working in partnership, we are drawing on lessons learned to develop considerations that may inform recommendations for improving the program for the Legislature in 2027.

Today, HCAI is following up on comments and questions received during and after the last HEMAC meeting.

Received Comments and Questions

- Completeness of maternal measures data reporting
- Common characteristics of measures most likely to be identified as a top disparity
 - Example: HCAI All-Cause Unplanned 30-Day Hospital readmission
 - Example: Age groups
- Health Equity Plan evaluation concerns

Completeness of Maternal Measures Data

- **Issue raised:** The first year data suggest low completeness in maternal data reporting. This is mostly because the denominator included all GAC hospitals, rather than only those providing maternal care.
- **Data gap:**
 - Under current regulations, HCAI doesn't formally collect information identifying which hospitals provide maternal care.
 - Although this information exists outside the HEM program, HCAI is constrained by regulations regarding what can be reported publicly.
- **Future consideration for 2027**
 - Clarify and appropriately define the denominator through future regulations and/or guidelines by adding a question to identify whether a hospital provides maternal care so that this information can be collected within the HEM program and used in HEM reporting.

Received Comments and Questions

- Completeness of maternal measures data reporting
- Common characteristics of measures most likely to be identified as a top disparity
 - Example: HCAI All-Cause Unplanned 30-Day Hospital readmission
 - Example: Age groups
- Health Equity Plan evaluation concerns

Common characteristics of measures most likely to be identified as a top disparity

**Data
completeness and
counts**

**Care complexity
post-inpatient
stay**

Clinical risk

Reference group

Common characteristics of measures most likely to be identified as a top disparity

**Data
completeness and
counts**

**Care complexity
post-inpatient
stay**

Clinical risk

Reference group

- For some measures, there is more complete data or greater ability to have more complete data
 - Ex. Hospitals generally have more complete data for readmissions, making disparities easier to detect
 - Ex. Age is consistently captured and complete in hospital data, making disparities easier to detect
- For other measures, there are small numbers even with complete reporting.
- **Future considerations for 2027**
 - Look at measures with small numbers as part of 2027 recommendations and their continued use
 - Consider DDG strategies presented in the next agenda topic

Common characteristics of measures most likely to be identified as a top disparity

Data
completeness
and counts

Care complexity
post-inpatient
stay

Clinical risk

Reference group

- Transitions of care – such as medication management, discharge instructions, and follow-up coordination – present greater challenges.
 - Particularly even greater for older age groups, amplifying disparities
 - Ex. The readmission measure captures a broad range of clinical and operational factors—care transitions, communication failures, outpatient access—making it more likely to reveal underlying inequities.
- **Future considerations for 2027**
 - As hospitals improve the completeness and reporting of other required measures, the ability to identify disparities in those areas will strengthen over time.
 - Reassess required measures as part of the 2027 recommendations

Common characteristics of measures most likely to be identified as a top disparity

Data
completeness
and counts

Care complexity
post-inpatient
stay

Clinical risk

Reference group

- Greater prevalence of chronic conditions and complications increases measured disparities across many HEM metrics for specific groups such as older age
- For certain measures, within certain measures or within certain strata, there is varying underlying risk or severity of illness
- **How do we account for the underlying variance in the methods used to fulfill the HEM requirements?**
 - This is a complex issue because the ability for hospitals to do risk adjustment varies considerably
 - Approaches
 - How we identify reference groups
 - Other approaches?

Common characteristics of measures most likely to be identified as a top disparity

Data
completeness
and counts

Care complexity
post-inpatient
stay

Clinical risk

Reference group

- Questions raised
 - Using a reference group with small numbers
 - Using the best performing reference group
 - Within hospital reference groups versus statewide or national reference group
 - Not accounting for risk to disparity considerations
- Ex. Age: Rather than using the best performing stratification group as the reference rate, consider alternative options such as a statewide rate for each age group allowing for within age group comparisons rather than across age groups
- **Future considerations for 2027**
 - Changes to guidelines for selecting reference groups

What Early Experiences Confirmed: Data Completeness, Data Count, Stratification and DDG Challenges

- Measures with high completeness and/or high counts

These measures have greater likelihood of identifying a disparity and being included among the top ten identified disparities (ex. 30-day readmission rates).

- Measures with historically low completeness or small sample sizes

Certain measures, such as those related to psychiatric hospitals or SOGI data, have historically faced challenges with lower completeness and/or small sample sizes. These measures will require reconsiderations

- Limitations when stratified

Some measures may appear robust overall but reveal issues with small sample sizes when analyzed by specific stratifications (ex. AHRQ measures). This provides an opportunity to gain insights from the first-year of implementation.

Received Comments and Questions

- Completeness of maternal measures data reporting
- Common characteristics of measures most likely to be identified as a top disparity
 - Example: HCAI All-Cause Unplanned 30-Day Hospital readmission
 - Example: Age groups
- Health Equity Plan evaluation concerns

Evaluation of Health Equity Plans

Identify lessons learned and program improvement opportunities

- Structured review of a sample of health equity plans
- Identify lessons learned, gaps, and best practices

Develop methods for a future statewide report and analysis of health equity plans

- Developed methods need to consider limited HCAI resources and the HEM Reporting Program being a transparency reporting program

Review of Health Equity Plans

- The example rubric presented by Convergence Health Consulting identified:
 - Lessons learned that align with topics presented in this agenda item today:
 - Small counts and DDG methods limit measure reporting and identifying disparities
 - Variance in counts that are a reflection of hospital size, location, population served, and hospital type that limit measure reporting and identifying disparities
 - Qualitative insights presented in Health Equity Plans are as valuable as quantitative findings
 - Particularly where small counts and DDG methods limited quantitative findings
 - Variance in completeness of data reporting and opportunities for technical assistance and improved data standardization
- Pros/cons to be considered in developing methods for a future statewide analysis of Health Equity Plans

Background

- 2022-2023: After open deliberation, HEMAC recommended a set of measures.
- 2024-2025: Measures were formally adopted through the regulatory process, with the understanding that initial years of data reporting would provide critical lessons learned.
- 2025-2026: The first year of data reporting has identified lessons learned for improving the program
 - Lessons learned were presented at the last HEMAC meeting. Comments and questions were received that requires partnership and deliberation of solutions for the 2027 recommendations

Goal: working in partnership, we are drawing on lessons learned to develop considerations that may inform recommendations for improving the program for the Legislature in 2027.

Today, HCAI is following up on comments and questions received during and after the last HEMAC meeting.

A Lessons Learned Framework for 2027 Considerations (For all measures)

Impact of masking (DDG) and stratification on counts?

Reference group
Should reference group "method" be specific to the measure?

Variability in underlying patient risk.
How to account for variability without risk-adjustment?

Balance between method complexity, method variation for different measures, hospital burden, amount of TA needed relative to resources available, "usability and "actionability" of what is reported?

Importance of a topic or population being included in the measure set and data where other concerns for the measure exist?
(e.g. limited completeness, small sample sizes, method complexity, hospital burden)

A Lessons Learned Framework for 2027 Considerations

Completeness	Counts	Considerations/Questions
High	Large	Retain the measure
Low/varying	Large	Can completeness be improved? How?
High	Small	Can new methods for masking/DDG address small count limitations?
Low/varying	Small	Can completeness be improved? How? Can new methods for masking/DDG address small count limitations?

A Lessons Learned Framework for 2027 Considerations (For all measures)

- De-identification and the impact of masking
 - We will begin here in our discussion of possible solutions with agenda item #7 today