HCAi Department of Health Care Access and Information
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Office of Health Care Affordability Quality and Equity Measure Set
April 22, 2025
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
2/14/25	Rachel McLean, California Department of Public Health	See Attachment #1
2/21/25	CA Bridge	See Attachment #2
2/21/25	California Association of Health Plans (CAHP)	See Attachment #3
2/21/25	California Hospital Association	See Attachment #4
2/21/25	Health Access California	See Attachment #5

From: McLean, Rachel@CDPH <Rachel.McLean@cdph.ca.gov>
Sent: Friday, February 14, 2025 6:54 PM
To: HCAI OHCA <OHCA@HCAI.ca.gov>
Subject: Comments on OHCA Quality and Equity Measure Set

Dear Office of Health Care Affordability:

Thank you for the opportunity to provide comments on the proposed OHCA Quality and Equity Measure Set. I am writing in support of your proposed inclusion of the DMHC postpartum care and **timely prenatal care** metric for all payers. This is particularly important for preventing congenital syphilis.

Syphilis during pregnancy can lead to stillbirth, miscarriage, infant death, and maternal and infant morbidity, which are preventable through appropriate screening and treatment. Many congenital syphilis cases in California have occurred among infants whose birthing parents report: receiving late or no prenatal care, using methamphetamine and injection drugs, experiencing homelessness or unstable housing, and/or having been incarcerated within the prior 12 months. In order to improve timeliness of prenatal care, OHCA should consider why pregnant people may not feel safe accessing prenatal care.

- A CDPH analysis found that, from 2020-2022, there were 1,175 congenital syphilis cases in the California Project Area (all counties excluding Los Angeles and San Francisco). Sixty-four percent (757) of birthing parents were diagnosed with syphilis before delivery. Of these 757, 45% (337) did not receive prenatal care, 20% (151) were not tested at first prenatal visit, and 4% (30) were not tested during early third trimester. This is despite California law requiring that clinicians delivering prenatal care offer syphilis screening consistent with CDPH guidelines.
- For all pregnant persons, regardless of risk behaviors, CDPH now recommends screening for syphilis three times – once at confirmation of pregnancy or at the first prenatal encounter (ideally during the 1st trimester), early in the third trimester (at approximately 28 weeks gestation or as soon as possible thereafter), and again at delivery. This change to universal three-time screening in pregnancy is consistent with new recommendations recently put forth in April 2024 by the American College of Obstetricians and Gynecologists (ACOG)[5] and has been implemented in multiple other states.
- In the CDPH analysis of congenital syphilis cases from 2020-2022, birthing parents who used methamphetamine (42%, 317) and/or experienced homelessness (20%, 152) were more likely to have not received prenatal care ($p < .05$). In the context of criminalization of pregnancy, it is imperative that payers and providers create a safer environment for pregnant people experiencing unstable housing or substance use disorder to access prenatal care. The Academy for Perinatal Harm Reduction has excellent recommendations for how to do so; the American College of Obstetrics and Gynecology (ACOG) also has guidelines promoting evidence-based and patient-centered approaches to substance use during pregnancy. OHCA should consider disseminating these guidelines to payers.

Thank you for your consideration.

Rachel

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February 21, 2025

Ms. Elizabeth Landsberg
Director, Department of Health Care Access and Information (HCAI)
2020 West El Camino Avenue
Sacramento, CA 95833
Transmitted by Email:
ohca@hcai.ca.gov

Re: Comments on Quality and Equity Measure Set

Dear Director Landsberg:

Thank you for the opportunity to comment on the Office of Health Care Affordability's Quality and Equity Measure Set. On behalf of the CA Bridge, a statewide organization promoting emergency department interventions to reduce overdose deaths and substance use disorders, we urge you to consider the inclusion of HEDIS measures on post emergency department follow-up care for patients with SUD.

Substance Use Disorders (SUD) remain one of the most pressing health challenges in our communities. Despite advancements in SUD awareness and education over the past couple of years, SUD-related deaths continue to rise.

- In 2023, approximately 12,710 Californians died because of fentanyl and other overdose deaths— an increase of over 160% since 2017. California's overdose death toll increased by 4% in 2023, while the number of deaths nationally declined for the first time in five years.

- Excessive alcohol use resulted in an additional death toll of almost 20,000.

- Drug-related overdose deaths were the sixth-leading acute cause of death, with an age-adjusted death rate of 26.9 per 100,000 residents in 2021. The drug-related overdose age-adjusted death rate was greater than the age-adjusted death rates for Chronic Obstructive Pulmonary Disease (COPD), lung cancer, kidney diseases, and congestive heart failure.
- The fatal overdose crisis disproportionately impacts Blacks/African Americans. Blacks/African Americans are the most overrepresented amongst overdose fatalities. They represent 6% of the population but 13% of all overdose deaths as of 2021. Fatal overdose rates are rising fastest among Blacks/African Americans, Hispanics/Latinos, and Native Americans. Blacks/African Americans, Hispanics/Latinos, and Native Americans have

experienced 208%, 201%, and 150% increases in age-adjusted overdose mortality rate since 2017, respectively.

- Almost 94% of Californians have health insurance coverage, which includes treatment for substance use disorder.

Emergency departments are often the first point of care for individuals with SUDs, providing immediate treatment, timely diagnoses, and connections to ongoing care. Based on an analysis of 2021 HCAI data, approximately 1.12 million patients with at least one primary or secondary diagnosis for any substance use disorder are reported to have visited emergency departments (ED) in California in 2021 - about 1 in 7 of all ED visits. We are now in the process of updating this analysis with HCAI's recently released 2022 data.

One critical barrier of effective treatment of SUD is follow-up care. Nationally, the NCQA reports that 30-day follow-up rates for all SUDs are similarly low, with Commercial PPO and HMO plans averaging 13.8% and 15.0%, respectively, and Medicare HMO and PPO plans reporting just 12.2% and 11.8%. As reported by DHCS, the HEDIS measure for post-emergency department follow-up care found that only 28.6% of Medi-Cal members who visited an emergency department for an overdose or SUD diagnosis received follow-up care after 30 days.

Based on our review of the proposed OHCA Quality and Equity measures for Payers and Physician Organizations, it appears that no measure related to SUD treatment or follow up care was included. The measure set for hospitals includes "Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge," however it *only* applies to acute psychiatric hospitals.

In our view, the failure to include performance measures related to SUD is a missed opportunity for addressing one of the most deadly and pervasive health challenges of our time. For this reason, we urge inclusion of the HEDIS measure for post emergency department follow-up care for SUD.

Although SUD issues are often an underlying driver of other health care costs including unnecessary ED visits and hospitalizations, it also contributes to the homelessness crisis and added criminal justice costs. SUD is often an overlooked medical condition. However, the inclusion of SUD performance measures could dramatically expand awareness and effectiveness of treatment that can reduce overdose deaths and relapse.

Again, we appreciate your efforts in advancing the goal of improved health care quality and equity. Please let me know if we can provide additional information on these issues.

Sincerely,

Aimee Moulin MD
PI California Bridge
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CA BRIDGE a program of the Public Health Institute

OHCA Proposed Quality and Equity Measure Set – CAHP Comments (*dated 02/21/25*)		
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N/A	General Feedback	CAHP supports the use of DMHC's HEQMS standards to align with what other regulators are doing for payers, and the proposal to use OPA and HCAI reporting for providers and hospitals. We appreciate OHCA's diligent efforts to coordinate with DMHC and other industry partners to leverage existing data and identify measures consistently used across organizations. With that in mind, we also request that OHCA consider and/or clarify the following:
		
		• **Will this require an additional file from payers? Medical Groups? Or Hospitals?**
		• **Will payers be expected to report the metrics for payers, hospitals, and provider organizations, or will hospitals and physician organizations be expected to report their own data directly to the state?**
		• **How much of this data can payers pull from existing DMHC submissions?**
		  ○ More info needed on data parameters (and stratification of measures by line of business)
		• **We recommend OHCA set expectations with providers and employers (for race, ethnicity, language) that they must provide complete data for required measures. Otherwise, the info is incomplete and not accurately reflected.**
		  ○ Even with previous state mandates, some providers have pushed back or not shared certain data elements with payers.
		• **Similarly, some of the race and ethnicity data required for health plan stratification is not provided to payers by employers.**
		  ○ We recommend OHCA provide guidance or ensure that employers are sharing this information with payers.

12	Measures for Payers	**General Comment** One recommendation is to consider placing a 10-measure ceiling on the number of measures tracked and reported. Increasing reporting year over year will only increase administrative costs while driving

OHCA Proposed Quality and Equity Measure Set – CAHP Comments (*dated 02/21/25*)		
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		down efficiencies that can be gained by focusing on specific improvements that can affect positive change.
12	Measures for Payers	**Childhood Immunization Status+** One recommendation is to implement Combo 7 instead of Combo 10. At this stage, not all parents want every single vaccine, and vaccine hesitancy plays a role in compliance with this measure. For the Covered California Exchange, the most commonly missed vaccine is the flu shot with NO available supply in California between May – September (i.e., it is impossible to get babies compliant with all the required vaccines needed for Combo 10).
12	Measures for Payers	**Glycemic Status Assessment for Patients with Diabetes (<8.0% and/or >9.0%)+** OHCA appears to include 2 diabetes measures (<8% and >9%). Both are not necessary, and we recommend implementing the >9% measure, considering that NCQA is moving in this direction.
12	Measures for Payers	**Child and Adolescent Well-Care Visits** It appears OHCA included two adolescent measures. We recommend narrowing to one measure to avoid unnecessary duplication, and the Well Visit measures is preferred.
12	Measures for Payers	**All-Cause Readmissions** We recommend OHCA remove this measure and focus instead on the hospital reported measure. Readmissions are more actionable at the facility level rather than the plan level.
12	Measures for Payers	**Depression Screening and Follow-Up** There are ongoing significant challenges in accurately capturing care and services due to the nature of the codes and tools used to capture depression screening and follow-up. Additionally, the DMHC will

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		reconvene its Health Equity and Quality Committee this year to discuss behavioral health measures specifically, because depression screening cannot be reported by behavioral health plans so there is a gap in the oversight process, and the goal of reconvening the Committee will be to develop a list of behavioral health measures that will be reported to the DMHC. We recommend ongoing monitoring without public reporting until the challenges can be addressed.
12	Measures for Payers	**CAHPS Health Plan Survey: Getting Needed Care** There is concern that this composite does not accurately measure a member's ability to get needed care. The survey is sent one time each year, and the snapshot does not pull from the entire membership. A member must meet continuous enrollment criteria first. The response rates for CAHPS surveys are also declining into the single digits across the country, and sometimes payers do not receive enough surveys returned to be scored on this measure (failure to meet case minimum). Additionally, the measure for urgent care is only applicable to the respondent who got urgent care and often the responses do not reach a statistically valid denominator.
12	Measures for Payers	**Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)** We recommend delaying publication of this measure for two years until the enhancements to DHCS newborn enrollment can be realized in the population.
13	Hospital Measures	**Screen Positive for Social Drivers of Health** We recommend removing this measure, as the Screening for SDOH measure should be sufficient. There is a recommendation to add a pain control measure for surgical and oncology patients.

California Hospital Association

February 21, 2025

Office of Health Care Affordability
2020 W El Camino Ave.
Suite 1200
Sacramento, CA 95833

Subject: **CHA Comments on the Proposed Office of Health Care Affordability Quality and Equity Measure Set**
(Submitted via email to Megan Brubaker)

California's hospitals are committed to advancing health equity — a key factor in helping all Californians reach their highest potential for health — and high-quality care. Hospitals alone cannot eliminate health disparities; it will take systemic reform and broad partnership to improve the status quo. The Office of Health Care Affordability's (OHCA's) work is an important first step toward reducing disparity; its efforts to reduce health care spending must be balanced against Californians' need for expanded and equitable access to high-quality care. To ensure these multiple — and sometimes competing — objectives are achieved, OHCA must comprehensively measure trends in access, quality, and equity. Hospitals look forward to working with OHCA to develop an innovative, inclusive framework that leverages existing data collection efforts and will deepen our shared understanding of health system performance related to access and equity. Unfortunately, **the currently proposed Quality and Equity Measure Set is missing several key elements and ultimately falls short of the holistic view needed to identify and protect against unintended consequences resulting from cost containment efforts**. The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to offer input and recommendations to achieve our shared goals of high-quality, affordable, and equitable health care for all Californians.

Proposed Approach to Quality and Equity Measurement Has Merit, But Will Not Comprehensively Capture Important Trends in Access, Quality, and Equity

Measuring Quality, Equity, and Access Is Necessary to Protect Against Unintended Consequences. OHCA is statutorily required to ensure that its spending targets do not impair access, quality, or equity. To carry out this purpose, state law requires OHCA to develop and track a set of quality and equity measures. In concept, CHA supports OHCA's efforts to track overall health care system performance and

encourages implementation of a comprehensive and innovative approach to measuring and protecting against the unintended consequences of OHCA's cost containment efforts. However, the current proposal fails to include certain information that is vital to that understanding.

Critical Aspects of Health Care System Performance Would Not Be Tracked Under OHCA's Proposed Approach. The proposed approach to quality and equity measurement would provide only a partial view of health care system performance. OHCA should use existing data collected by government agencies and other organizations to fill the gaps created by the following omissions:

- **Access Measures Are Essentially Absent.** By including almost no access measures, the proposed approach to quality and equity measurement would result in a serious lack of insight into many critical measures of health system performance. The OHCA board would have no way of knowing whether:
  - Appointment and emergency department wait times are increasing
  - Patients are forced to travel farther for emergency care or labor and delivery services
  - Patients are experiencing greater difficulty obtaining a usual source of care
  - Networks of behavioral health therapists are decreasing
  - High-value — if sometimes high-cost — pharmaceuticals and other new health care technologies are growing further out of reach
  - Patients with rare diseases like hemophilia, cystic fibrosis, or muscular dystrophy are facing greater challenges obtaining the care they need to survive

  The OHCA board should direct OHCA staff to develop a supplemental plan for comprehensively measuring access to care, including for patients with chronic and rare diseases, and thereby strive to fulfill its mandate to maintain access to care while reducing spending growth. As required under state law, OHCA should use existing data collected by government agencies and other organizations to fulfill this task.
- **Quality and Equity Measures Ignore the Outcomes California's Health Care System Must Achieve.** California's health care system produces miracles every day, extending and saving lives from diseases and injuries that, one or more decades ago, would have led to certain death or impairment. And yet, **OHCA's proposed quality and equity measure set does not focus on the health care system's primary function: improving people's health.** Instead, the majority of the measures only look at preventive care processes, like whether a patient received a screening or whether just one of several specific kinds of visits occurred (e.g., well-child and prenatal visits). While the proposed measures may reflect sound **process measures**, the relative lack of true **outcome measures** — especially for entities other than hospitals — may leave OHCA with the mistaken impression that the system is performing as hoped, even while its most fundamental functions are degrading or no longer achieving their full potential. To address this deficiency, the OHCA board should ask OHCA staff to incorporate additional outcome measures into the non-hospital measures sets.

- **Creation and Diffusion of New Treatments Deserve Special Attention.** A major risk of OHCA's efforts to reduce spending is slowing the rate of innovation in health care and how quickly these innovations become available to patients. This chilling effect on innovation would cause untold avoidable disease and death. Recent analysis from the National Bureau of Economic Research underscores the reality of this risk[1], showing that a 61% reduction in Medicare payments for medical devices led to a 25% decline in new product introductions and a 75% decrease in patent filings, both indicating a slowdown in innovation. New entrants into the manufacturing market fell while outsourcing increased, leading to poorer device quality. As a result, the authors estimate that the price cuts potentially led to losses in the value of foregone innovation far exceeding the amount of Medicare dollars saved. OHCA's spending target aims to reduce total health care spending growth by almost 40% over the next five years, with potential for similar troubling effects. **Monitoring such unintended consequences is critical for OHCA to meet its mission without damaging the health of 39 million Californians.**

Approach to Measuring Hospital Quality and Equity Is Generally Sound, But Changes Should Be Considered Over Time

Using Existing Hospital Measures Has Significant Benefits. OHCA has proposed to use a slate of pre-established quality and equity measures to track health care system performance. As part of that proposal, OHCA staff have recommended using the same measures as the Hospital Equity Measures Reporting Program developed by its parent department, the Department of Health Care Access and Information (HCAI), over the past several years. This approach has major advantages — most notably, compliance with the provision in state law that OHCA leverage pre-existing measures used by other regulatory bodies. Furthermore, reliance on existing measurements would minimize administrative complexity for both OHCA and hospitals, as well as reduce the degree to which hospitals are asked to adhere to disjointed sets of quality and equity performance measures that may support differing objectives. **Streamlining quality and equity performance measurement under a standard set would allow hospitals to focus their resources on meaningful improvement on a discrete set of measures.**

Data Collection and Analysis Will Be Challenging, Requiring Additional Resources. Collecting the required data for the Hospital Equity Measures Reporting Program will be challenging for hospitals and new for patients, especially given the sensitivity of select information. Hospitals will need to conduct comprehensive staff training to ensure a positive patient experience. In addition, HCAI has not yet made available standards for the sexual orientation and disability stratification categories; as a result, these data 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

[1] Yunan Ji and Parker Rogers. "The Long-Run Impacts of Regulated Price Cuts: Evidence from Medicare." NBER Working Paper No. 33083. October 2024. https://www.nber.org/papers/w33083

categories in different ways, providing OHCA with inconsistent data across the field. **HCAI must 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, it will be especially challenging for California's critical access, district, and rural hospitals. **When evaluating hospital spending, OHCA should recognize the significant process changes required for this reporting.**

Detailed Stratification of Measures Is Cumbersome and May Not Lead to Insightful Conclusions. Understanding how measures may vary by demographic variables is an important component of how OHCA's proposed interventions may impact the equity of care provided to California patients. However, detailed stratification may unintentionally create situations where data become less meaningful. The "All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis" measure clearly illustrates this challenge. Here, the default measure has three stratification levels: Mental Health Disorder, Substance Use Disorder and Co-Occurring Disorder. Then, hospitals are required to further subset each of these categories by nine additional demographic categories, some of which have many levels (e.g., Preferred Race/Ethnicity, which itself has eight levels). For many hospitals, including small or rural hospitals, this level of stratification will result in counts that are just above the California Department of Health and Human Services De-Identification Guidelines (DDG) minimum cell count of 11 to minimize potential re-identification, but still too small to yield statistically relevant comparisons with other hospitals. **HCAI should consider reducing stratification requirements for hospital-level reports to ensure that these significant efforts produce meaningful results.**

Misalignment of Measures for Payers, Physician Groups, and Hospitals May Lead to Data Inconsistencies. Data reporting for hospitals has far more stringent stratification requirements compared to reporting for payers and physician organizations. Hospitals appreciate the office's adoption of existing infrastructure outlined under Assembly Bill (AB) 1204 (Chapter 751, Statutes of 2021), which defines stratification requirements. Unfortunately, the current Department of Managed Health Care (DHMC) requirements for stratification that the office proposes for payers and physician groups splits race and ethnicity in two categories, while hospitals use a combined Race/Ethnicity category, in accordance with the current Office of Management and Budget (OMB) standard. The Measures Set Document mentions that DMHC will adopt the OMB standard as soon as possible. However, starting with this misalignment will preclude the office from making meaningful comparisons across sectors. The Measure Set Document also mentions that the office will consider applying additional stratification criteria to payers as they become available. **OHCA should consider this an area of flexibility in reporting for hospitals until these sectors can be aligned and payers and physician groups use the same stratification criteria to**

create a more cohesive view of how the health care system is performing under the proposed spending targets.

Despite Requirements, Measures Are Not Applicable to All Types of Hospitals.

- **Acute Psychiatric Hospitals.** While hospitals appreciate the alignment of OHCA measures with AB 1204 measures, the structural measures that rely on guidance from the Centers for Medicare & Medicaid Services (CMS) have been delayed 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, many acute psychiatric facilities will find collecting, analyzing, and stratifying data outlined in the OHCA measures to be a labor-intensive, manual process. To account for this additional challenge, OHCA should delay reporting for these facilities and align with the federal timeline.

  Additionally, acute psychiatric facilities do not and are not required to administer the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; patients with a psychiatric diagnosis are explicitly excluded from receiving the survey. OHCA should recognize that acute psychiatric hospitals are exempt from reporting on the HCAHPS measure and therefore will not provide information on this measure.

- **Rehabilitation Hospitals and Long-Term Acute Care Hospitals.**
  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 exempt from the data reporting requirement. 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 OHCA measure set reporting requirements. However, the majority of the OHCA Quality and Equity Measures do not apply to either hospital type. OHCA should specify that these hospitals are not required to comply with the proposed OHCA Quality and Equity Measures set at this time.

It Is Critical to Maintain Alignment With Evolving Federal Standards. In August 2024, CMS posted the hospital inpatient prospective payment system (IPPS) final update for fiscal year 2025 along with policy, reporting, and regulation changes. For the hospital inpatient quality reporting (IQR) program, CMS adopted seven new quality measures, removed five existing measures, and modified two measures. As a result, the several measures from the Proposed OHCA Quality and Equity Measure Set are changing and/or being removed from CMS reporting requirements (detailed below). OHCA and HCAI should

maintain alignment with these changes in federal reporting requirements to minimize administrative complexity for both HCAI and hospitals and focus attention on shared improvement goals.

Certain Measures Should Be Removed or De-Emphasized.

- **Remove 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 IQR beginning with the fiscal year 2027 payment determination (July 2023–June 2025 data), to be replaced with a more broadly applicable 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure. HCAI should remove PSI-04 as an acute hospital core measure.
- **De-Emphasize 2024 HCAHPS Results.** The HCAHPS survey is changing in 2025, making 2024 benchmarks invalid for future years. In addition, CMS has updated its scoring methodology under the Hospital Value-Based Purchasing (VBP) Program to account for these changes. The new version of the survey will not be fully scored under the Medicare VBP program until federal fiscal year 2030 to account for new benchmarks. HCAI should account for these changes to the survey.
- **Remove Agency for Healthcare Research and Quality (AHRQ) Quality Indicator 20 (IQI 20) Pneumonia Mortality Rate Core Measure for Acute Psychiatric Hospitals.** AHRQ IQI measures are not currently calculated or required for acute psychiatric hospitals. AHRQ IQI measures are calculated using hospital inpatient discharge data for general acute care hospitals **only**, so these data are not readily available for psychiatric, children's, rehabilitation, long-term care, or cancer hospitals. The resource involved in calculating this measure — assuming it is even possible to do so — far outweighs any potential value.

Conclusion

To successfully achieve its dual goals of improving health care affordability while promoting access, equity, and quality, OHCA must measure and report on the data that best illustrate health care system performance — and the office must allow for learning and improvement along the way. Trends related to access, quality, and equity are essential components of such a performance dashboard. While the hospital measures OHCA proposes to use are relatively comprehensive and generally feasible in terms of implementation, significant gaps in OHCA's overall quality and equity measurement plan must be addressed.

Sincerely,

Victoria Valencia
Vice President, Data Analytics

HEALTH ACCESS CALIFORNIA

February 21, 2025

Megan Brubaker
Office of Health Care Affordability

Department of Health Care Access and Information
2020 W. El Camino Ave., Ste. 1200
Sacramento, CA 95833

Re: Proposed Quality and Equity Measure Set

Dear Ms. Brubaker:

Health Access California, the statewide health care consumer advocacy coalition, is committed to quality, affordable health care for all Californians. As a part of its mission, Health Access seeks to improve the value of health care for Californians and reduce disparities while slowing cost growth. In line with Health Access' objectives, Health Access offers the following comments on the proposed Office of Health Care Affordability (OHCA) Quality and Equity Measure Set.

Health Access Recommendations:

- Addressing Data Limitations
- Data stratification by age and market segment
- Expanding upon measures
- Behavioral Health Considerations
- Periodically Revisiting Measures

Addressing Data Limitations

As OHCA continues to refine the measure set, addressing limitations and gaps in evidence will be crucial in improving the identification and reduction of disparities. OHCA has made progress in utilizing measures adopted by other state government agencies. While this is a strong foundation, we encourage OHCA to further leverage existing measure sets from other agencies such as the California Department of Public Health (CDPH) to enhance the comprehensiveness of health measures.

We are troubled that the OPA Health Care Quality Report Cards assess the quality of care provided by physician organizations; however, these measures are not stratified by race or ethnicity, or other relevant variables. We encourage OHCA to stratify physician organization measures by sexual orientation, gender, race and ethnicity if and when such data becomes available from other agencies or sources. Supplemental data metrics can

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also be used to fill knowledge gaps, as combining different data sources can provide a more complete picture of gaps in healthcare access. As OHCA continues to collect data on recognized measures, we urge the incorporation of additional measures to better identify and address disparities, in order to improve equity in health outcomes**.**

Additionally, it is essential to push for improved measure sets and data analysis from agencies while finding innovative ways to utilize existing data, particularly when the sample sizes are small. When working with smaller or dispersed data points, it is important to recognize that disparities for particular populations still may exist, even If they appear statistically rare and insignificant. This can be achieved by regionally grouping data or incorporating multi-year datasets.

Partnering with research institutions can also further support data analysis by leveraging their expertise in health equity research and advanced analytical methodologies. This collaboration could refine the analysis that has already been done and ensure the identification of disparities that may not be immediately evident, such as those hidden in underrepresented populations. Research institutions can also contribute to the discovery of innovative approaches, using qualitative research and help with the development of proxy indicators for social determinants of health. Such advances would provide further insights into health inequities when direct data is limited or unavailable.

Data stratification

Health Access encourages OHCA to go beyond stratifying for race and ethnicity and sexual orientation and gender identity (RELD-SOGI) data and demographics as permitted under Section 127503 (a)(5). We appreciate the stated intention of the Office to assess options for stratification of measures for physician organizations in the future and to explore equity analyses by other state departments.

As emerging measures become available, we also encourage OHCA to integrate additional stratification that accounts for social determinants of health, which plays a pivotal role in health outcomes. Factors such as caregiving responsibilities, housing stability, food security and transportation access can influence an individual's ability to access or afford care. For example, plans that provide access to doulas have demonstrated improved maternal outcomes, particularly in marginalized communities, even though programs such as these can be hampered by broader structural disparities. By incorporating these additional equity stratifications in the future as they become available and reliable, OHCA can build upon this initial measure set to gain a more granular understanding of disparities in quality and equity.

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Additionally, stratifying by healthcare market segments, such as Medicare, Medi-Cal and commercial coverage, will be critical for identifying differences in accessibility and quality of care and aligning with measurement of cost target achievement. Each market segment has varying levels of coverage, including benefits, copayments, deductibles and premiums, which could be a significant obstacle to healthcare utilization. Higher costs can serve as a barrier to using healthcare services, which leads to poorer health outcomes. By implementing stratification, healthcare organizations and OHCA identify gaps in preventative care.

Expanding upon measures

Health Access supports the proposed measures provided for hospitals and recommends inclusion of the California Department of Public Health's (CDPH) measures on health acquired infections as a measure set. Health acquired infections continue to be a safety and quality care concern for patients, as demonstrated decades ago by the Institutes of Medicine' landmark piece on patient safety. CDPH has been collecting and enforcing health-acquired infection measures for twenty years, leading to significant improvements in quality, and the reduction of patient harm. These measures have had a lasting impact and carry important equity implications. CPHEN has sponsored legislation, with support from Health Access. Incorporating CDPH's data collection would enhance OHCA's understanding of current infection trends and disparities among patients' infection rates.

Behavioral Health Considerations

We recognize OHCA's efforts to incorporate behavioral health into its measure set, beginning with introducing the Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen) and substance use measures. As OHCA continues to enhance its measure set, we encourage the exploration of additional behavioral health indicators.

OHCA should encourage Improving the development of behavioral health measures. The continued coordination between agencies such as Substance Abuse and Mental Health Services Administration SAMHSA can facilitate better data collection and integration. Additionally, leveraging data from emergency room visits and supplementing it with other sources can provide insight into whether the health system in California is making progress toward the behavioral health benchmark under consideration by the Office which would shift the focus of behavioral health away from the emergency room (and jail) to the prevention and management of these conditions.

Periodically Revisiting Measures

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Finally, the statute (H&S Code 1275-3 (c)) requires that the Office annually review and update the Equity and Quality Measure Set. Health Access also suggests that a more thorough look every five to seven years is likely to be in order as measure sets and measurement evolve and the ability to stratify data improves. Both annual updating and a more extensive periodic review will help ensure that newer data sources and measures can be incorporated as appropriate and to ensure the measure set continues to remain relevant in the context of changing healthcare systems and norms.

Sincerely,

Katrina Walters-White, MBA
Regulatory Advocate

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