AMERICA'S ESSENTIAL HOSPITALS

September 27, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

**Ref: Enhancements of the Overall Hospital Quality Star Rating System**

Dear Ms. Verma:

Thank you for the opportunity to submit comments on the most recent report from the Centers for Medicare & Medicaid Services' (CMS') contractor tasked with developing the overall hospital star rating system for the Hospital Compare website. The report includes the contractor's re-evaluation and proposed enhancements of the star rating methodology.

America's Essential Hospitals appreciates CMS' efforts to encourage transparency in care delivery across the entire health care industry, and we support sharing meaningful hospital quality information with patients. However, our member hospitals remain concerned about the overall hospital quality star rating system, including issues with its methodology and doubt about whether it accurately reflects the quality of care provided by essential hospitals. We urge the agency to suspend overall star ratings and mitigate flaws in the system's measures and methodology. This would prevent confusion among patients and providers and ensure a meaningful and accurate assessment of quality at hospitals nationwide.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Filling a vital role in their communities, our 325 member hospitals provide a disproportionate share of the nation's uncompensated care and devote nearly three quarters of their inpatient and outpatient care to Medicare, Medicaid, and uninsured patients. Essential hospitals treat more patients dually eligible for Medicare and Medicaid than the average hospital. These patients often have multiple comorbidities and chronic conditions and are among the most difficult to treat. Through their integrated health systems, members


AMERICA'S ESSENTIAL HOSPITALS
401 Ninth St NW Ste 900
Washington DC 20004
t: 202 585 0100
f: 202 585 0101
e: info@essentialhospitals.org

of America's Essential Hospitals offer primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to disadvantaged patients.

We previously voiced concern to CMS about the overall star rating methodology; we since have heard similar uncertainties and confusion from our members about the appropriateness of the methodology and selected measures, as well as the usability for patients of the overall star rating. We believe there is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients receive lower star ratings despite providing quality care, often to disadvantaged populations. Patients' abilities to make well-informed choices are impaired by this one-size-fits-all model that does not reflect the full picture of hospital care. Flaws in the methodology, such as a lack of risk adjustment for factors outside hospitals' control, are unknown to patients when viewing an overall star rating.

Given these significant concerns, we ask CMS to suspend the overall star rating system and consider the following comments to re-evaluate the methodology. Doing so would prevent a disproportionate effect on essential hospitals and confusion among the vulnerable populations they serve.

1. CMS should re-evaluate the appropriateness of an overall hospital star rating that oversimplifies the complex and individualized choices patients must make about their health.

Similar to its websites for other health care facilities, CMS combines the scores of a select number of Hospital Compare measures to determine overall hospital ratings of one to five stars, with five stars being best. The intent of the star rating is to provide information patients can use when deciding where to receive care. If the information does not accurately account for health care quality or is not comprehensible and useful, it can lead to misinformed choices.

a. CMS should clarify how the hospital overall star rating system differs from existing star ratings for other providers, and should ensure the hospital ratings do not oversimplify a complex and individualized decision—a patient's choice of care—while potentially exacerbating disparities in care.

Because the CMS star rating system for hospitals is relatively new, studies of its effects on patient decisions and access to care are limited. Lessons learned from research on the star rating systems used by CMS in Nursing Home Compare might provide critical insights into its effect on health care quality in the hospital setting. One study found the star rating system exacerbates disparities in care quality over time in nursing homes: dual-eligible patients were substantially less likely to choose the highest-rated nursing homes once the five-star rating system began, compared with their non–dual eligible

peers.[1] CMS should clarify how the hospital overall star ratings differ from existing star ratings for other providers. Further, the agency must ensure that a patient's choice of care—a complex and individualized decision—is not oversimplified and that disparities in care are not exacerbated. **We urge CMS to more closely examine the existing hospital star rating system and the underlying data, paying particular attention to potential unintended effects on essential hospitals, which treat vulnerable, disadvantaged populations.**

b. CMS should re-evaluate the appropriateness of having one overall rating for hospital quality that does not take into account the individualized care choices of patients.

Under the methodology for the overall hospital star ratings, CMS chose a select group of measures from those listed on Hospital Compare to generate a star rating based on metrics that are actively collected and reported. America's Essential Hospitals supports the use of existing measures to minimize administrative burden, but we are not confident that the measures currently available on Hospital Compare enable CMS to create a single, methodologically sound rating of all aspects of hospital quality.

The publicly released overall star ratings provide information patients might use when deciding where to receive care. While CMS intended to provide patients a simplified assessment of hospital quality in developing such a rating, each patient's circumstances are different and the quality measures most relevant to their care will differ. For example, a patient undergoing an orthopedic procedure likely will be interested in a hospital's complication rate after such a procedure; in contrast, a patient deciding where to give birth might be most interested in rates of cesarean section. If the information is presented in an inaccurate and useless way, or if it misrepresents the quality of care provided by certain types of hospitals, it can lead a patient to make choices against his or her best interest. **CMS should ensure that the methodology for overall star ratings provides actionable information based on coherent sets of hospital quality measures, and that ratings are relevant to patients' individualized care choices.**

2. CMS should only include in the hospital overall star rating methodology measures that accurately reflect quality of care, and the agency should risk adjust the measures to account for the sociodemographic factors, which complicate care for vulnerable patients.

Essential hospitals treat a high proportion of patients with social risk factors that are outside the control of the hospital—including lack of transportation for follow-up care and limited access to nutritious food—that can affect health outcomes. The overall star rating methodology does not account for hospitals that serve highly complex patients with significant sociodemographic challenges and that perform a greater number of

[1]Konetzka RT, Grabowski DC, Perraillon MC, Werner RM. Nursing Home 5-Star Rating System Exacerbates Disparities in Quality, By Payer Source. *Health Affairs.* 2015;34(5):819–827.

complex surgeries. Without proper risk adjustment, an essential hospital serving a disproportionate share of lower-income patients with confounding sociodemographic factors might be rated lower for reasons outside its control.[2] Further, excluding these factors will lead to inaccurate and misleading ratings, as evidenced by the public release of the ratings thus far.

Many of the nation's best-known hospitals, including institutions that serve low-income and complex patients and that are highly rated in other quality rating reports, have received one- or two-star ratings due to the methodology. A high percentage of the star rating is allocated to measures with data reflecting performance periods two or even three years prior, which is misleading to consumers because the scores and resulting rating does not reflect current hospital performance. **We urge CMS to work to mitigate the lag in reported performance to better reflect real-time quality improvement efforts by essential hospitals.** Additionally, the ratings rely heavily on the claims-based patient safety for selected indicators (PSI-90) composite measure, which fails to accurately gauge clinically relevant complications, and similar metrics. Many of our member hospitals provide high-risk procedures, such as cancer surgery, often not performed at the facilities against which they are measured; such procedures involve a higher risk of related conditions, including accidental puncture or laceration.[3] Events captured in the PSI-90 composite measure occur disproportionately in teaching hospitals and hospitals providing highly specialized services and, therefore, are not reflective of a true difference in performance when compared with other types of hospitals. In these cases, the higher risk of infection does not reflect poor quality of care at the hospital, but rather reflects the types of procedures performed. Further, since the claims data used in calculating the PSI-90 metrics are not clinically validated, the data do not accurately represent the quality of care provided at a hospital. Hospitals can track clinically based data and monitor patients' progress based on the entirety of their clinical record. Placing excessive emphasis on claims-based data does not reliably represent a hospital's progress in improving quality. **CMS should remove the PSI-90 composite measure from the overall star rating system.**

Additionally, we have concerns about including Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data in the calculation of overall star ratings. America's Essential Hospitals analyzed CMS' June 2015 publicly reported star ratings of HCAHPS patient experience data collected from October 1, 2013, to September 30, 2014. Our analysis found that certain types of hospitals—specifically, larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients—were more likely than others to receive lower star ratings.[4] Research

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[2]Essential Hospitals Institute. Sociodemographic Factors Affect Health Outcomes. February 26, 2015. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed March 2016.

[3]Kin C, et al. Accidental Puncture of Laceration in Colorectal Surgery: A Quality Indicator or a Complexity Measure? *Diseases of the Colon & Rectum.* 2013;56(2):219–225.

[4]Roberson B, Rangarao S, McFann T. The Relationship Between Hospital Characteristics and CMS Star Ratings. Essential Hospitals Institute. September 2015. http://essentialhospitals.org/wp-content/uploads/2015/09/Star-Ratings-Brief3.pdf. Accessed September 2017.

also has shown a greater likelihood of low HCAHPS scores from patients admitted via the emergency department (ED), as patient-provider interactions often are more limited due to the stressful nature of the ED.[5] Hospitals with higher ED volumes might score lower even though their quality might be the same or better than hospitals with lower ED volumes. Such variation in star ratings, not based on the quality of a hospital itself, reflects a weakness of the star rating system.

Further, outcome measures in the overall star rating—especially those focused on readmissions—do not accurately reflect quality of care if they do not account for sociodemographic factors, including socioeconomic status, that can complicate outcomes. For example, patients who do not have a reliable support structure are more likely to be readmitted to a hospital or other institutional setting. America's Essential Hospitals, in previous comments on hospital inpatient quality reporting programs, urged CMS to consider the sociodemographic factors—language and existing level of post-discharge support, for example—that might affect patients' outcomes and include such factors in the risk-adjustment methodology. We made these comments out of a preponderance of evidence that patients' sociodemographic status affects outcomes of care.[6] **CMS should appropriately risk adjust outcomes measures in the overall star rating system to account for sociodemographic factors, including socioeconomic status.**

Most recently, in the fiscal year 2018 Inpatient Prospective Payment System rule, CMS finalized a transitional risk adjustment methodology for the Hospital Readmissions Reduction Program that allows separate comparison of hospitals based on a facility's proportion of dual-eligible patients; this comparison is used as a proxy for socioeconomic status.[7] However, stratification is not risk adjustment and more work must be done to account for social risk factors across Medicare programs.

As required by the Improving Medicare Post-Acute Care Transformation Act, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation in December 2016 released a report in which the connection between social risk factors and health care outcomes is clear.[8] The report provides evidence-based confirmation of what essential hospitals and other providers have long known: Patients' sociodemographic and other social risk factors matter greatly when assessing the quality of health care providers.

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[5]Kahn SA, Iannuzzi JC, Stassen NA, Bankey PE, et al. Measuring satisfaction: factors that drive hospital consumer assessment of healthcare providers and systems survey responses in a trauma and acute care surgery population. *American Journal of Surgery*. 2015;81(5):537–543.
[6]See, e.g., America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed August 2017.
[7]21st Century Cures Act of 2016, H.R. 34, 114th Cong. §15002 (2016) (enacted).
[8]Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 2016. https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf. Accessed April 7, 2017.

Further, as noted by the National Academies of Sciences, Engineering, and Medicine in its series of reports on accounting for social risk factors in Medicare programs, "achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control."[9] **We urge CMS to re-evaluate the overall star rating methodology in light of new evidence and changes to risk-adjustment in the hospital quality reporting programs. We also urge the agency to ensure the rating system appropriately accounts for hospitals treating patients with social and economic challenges.**

3. CMS should seek independent third-party review of the methodology to ensure the ratings give patients meaningful and accurate hospital quality information and do not disproportionately disadvantage any category of hospitals.

The proposed enhancements to the methodology reflect analyses performed by CMS' long-standing contractor—the same contractor that developed the star rating system. We feel strongly that there is a need for independent third-party review and analyses of the overall star rating methodology. Through this independent review, CMS can re-evaluate its methodology in an objective and transparent manner to ensure validity and appropriateness. Ultimately, hospitals and consumers expect a properly constructed rating system will provide meaningful results of the greatest use to patients, while accounting for the varying factors that affect hospitals' performance outcomes and not disproportionately disadvantaging essential hospitals.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

[9]National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. Washington, D.C.: The National Academies Press. January 2017. http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx. Accessed September2017.