March 29, 2019

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

Ref: Overall Hospital Quality Star Rating on Hospital Compare Public Input Request

Dear Administrator Verma:

Thank you for the opportunity to comment on the above-captioned request for public input on overall hospital quality star ratings. America's Essential Hospitals supports the efforts of the Centers for Medicare & Medicaid Services (CMS) to encourage transparency in care delivery across the entire health care industry and to provide consumers with information to make care decisions. We continue to hear from our members about concerns with the underlying methodology and overall usefulness of the ratings. We appreciate the agency soliciting feedback on how to improve the program and its willingness to act when it is clear there are problems with the ratings.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Filling a vital role in their communities, our 300 member hospitals provide a disproportionate share of the nation's uncompensated care. Three-quarters of our members' patients are uninsured or covered by Medicaid or Medicare. More than half of patients discharged from essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care essential hospitals are best able to provide.[1]

Through their integrated health systems, essential hospitals offer the continuum of primary through quaternary care, including trauma care, outpatient care in their

---

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2017 Annual Member Characteristics Survey.* America's Essential Hospitals. 2017.

essentialhospitals.org

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

ambulatory clinics, public health services, mental health services, substance abuse treatment, and wraparound services particularly important to disadvantaged patients. Many of the specialized inpatient and emergency services they provide are not available elsewhere in their communities.

Essential hospitals are continually called on to meet the complex clinical and social needs of the patients who come through their doors. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and pharmacy services, for example—not typically available at freestanding physician offices. Their ambulatory networks also offer behavioral health services, interpreters, and patient advocates, who can access support programs for patients with complex needs.

America's Essential Hospitals supports sharing meaningful hospital quality information with patients. But 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 the most vulnerable patients. **We urge CMS to suspend publication of the ratings and consider the following comments before moving forward, to avoid confusion among patients and disproportionate effects on essential hospitals.**

1. **CMS should ensure the star ratings do not oversimplify a complex and individualized decision—a patient's choice of care—while potentially exacerbating disparities in care.**

Hospitals, including essential hospitals, were the first providers to voluntarily supply quality data for the public and have been doing so for more than a decade. Our members are committed to transparency and accuracy in quality measurement. They understand the importance of quality improvement reporting, especially with increasing demands for accountability, movement toward value-based purchasing, and growing consumer engagement.

America's Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. Eighty-five percent of our members provide linguistic services versus about half of other acute-care U.S. hospitals.[2] Essential hospitals know the importance of sound data to reduce disparities in care, and they lead efforts to close gaps in quality for racial and ethnic minorities. By involving patients as active participants in their care, hospitals can better help them identify care choices, as well as responses to clinical and social needs that might improve health outcomes.

However, a single rating for a hospital oversimplifies what is an inherently complex and personalized decision—the choice of where to seek care. Further, a hospital's single,

---

[2] Ibid.

2

simplified rating might fail to capture its particular expertise in an area of care most important to a given patient. For example, a hospital's complication rate after an orthopedic procedure provides little useful information to a woman deciding where to give birth. Because each patient's circumstances differ, so, too, will the measures that matter to them.

CMS has chosen 57 measures from those listed on Hospital Compare, with the aim of generating a star rating based on measures that are actively collected and reported, widely available, suitable for combination, and easily interpreted by patients and consumers. But these measures do not always apply to all patients and, therefore, do not allow CMS to create a single, methodologically sound rating of all aspects of hospital quality. The star ratings must reflect cross-cutting measures that affect all patients. **We urge CMS to further examine the methodology for the star ratings and ensure that patients receive information on coherent sets of hospital quality measures in a way that is most relevant to their individualized care choices.**

2. **CMS should include only reliable and valid measures when calculating star ratings and ensure measure grouping and group weights are balanced and reflect what matters to patients.**

We strongly urge CMS to re-examine its methodology and ensure the types of measures included will provide meaningful results of the greatest use to patients, account for the varying factors that affect hospitals' performance outcomes, and not disproportionately disadvantage essential hospitals.

> a. CMS should consider removing the Patient Safety and Adverse Events (PSI 90) composite measure from the star ratings methodology.

America's Essential Hospitals is concerned the PSI 90 composite measure is an unreliable indicator of care quality. The events in this claims-based measure occur infrequently; are susceptible to surveillance bias; lack appropriate and necessary exclusions; might not be preventable through evidence-based practices; and are based on administrative claims data that cannot capture the full scope of patient-level risk factors.[3,4] Further, the PSI 90 composite measure focuses on surgical issues and, therefore, disproportionately influences ratings for academic medical centers and essential hospitals, which see a larger volume of complex surgical cases. Placing excessive emphasis on claims-based data unreliably represents a hospital's actual progress in improving quality. **We urge CMS to remove the PSI-90 composite measure and recalculate the star ratings.**

---

[3] Rajaram R, et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. *JAMA*. 2015;313(9):897–898.
[4] Cassidy A. Medicare's Hospital-Acquired Condition Reduction Program. *Health Affairs:* Health Policy Briefs. August 6, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142. Accessed June 4, 2018.

b. <u>CMS should further refine the measure grouping and group weights in a conceptually meaningful way that achieves measure loading balance.</u>

The seven star rating measure groups—mortality, readmission, safety of care, patient experience, process effectiveness, timeliness of care, and efficiency of medical imaging—were based primarily on clinical coherence and utility for consumers. CMS seeks specific input on alternative measure groupings for the safety of care measures. For example, CMS proposes that it could partition the eight measures now in the safety of care group into a new surgical safety group (e.g., hip/knee complications) and nonsurgical or medical safety group (e.g., central line–associated bloodstream infections).

Further input from stakeholders is needed to evaluate, both conceptually and empirically, the impact of regrouping and new group weights. Patients might seek care for services and treatments that simply are not reflected in the available measure data. In addition, the star ratings might make inappropriate assumptions about what matters most to patients facing particular health care decisions. **We urge CMS first to consider the types of measures that will provide meaningful results (that are most useful to patients) and take into account the different factors that affect hospitals' performance outcomes.**

Additionally, measures will be removed from Hospital Compare as CMS implements its Meaningful Measures initiative, with the goal of identifying high-priority areas for quality measurement and improvement and reducing provider burden. We urge the agency to only include measures in the star ratings that are endorsed by the National Quality Forum (NQF). **CMS should ensure the star ratings measure set, in its current state and as amended by future addition or removal of measures, includes only NQF-endorsed measures that are valid, reliable, and aligned with other existing measures.**

3. **CMS should examine ways to account for differences among hospitals to ensure the star ratings reflect actual quality of care within the hospital's control.**

Hospitals vary widely in the scope of services they offer and the acuity of their patients. Yet, the calculation of a single star rating for all hospitals treats them as if their overall performance is directly comparable. We urge CMS to account for differences between hospitals and factors outside hospitals' control that influence outcomes and ratings.

a. <u>CMS should risk adjust measures in the methodology to account for the socioeconomic and sociodemographic factors that complicate care for vulnerable patients.</u>

Essential hospitals routinely go above and beyond medical treatment in their care of disadvantaged patients. For example, one hospital in Florida introduced a program that ensures discharged patients have nutritious food—something vital to their recovery. The program combines a team of clinicians, social workers, and other health care

professionals to determine whether patients are malnourished or at risk for malnutrition after discharge. At-risk patients then are provided nutritional counseling during their hospital stay and are eligible to receive nutritionally balanced meals after discharge.

It is well-known that patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care provided.[5] Ignoring these factors at the measure level will skew ratings against hospitals that disproportionately care for the most complex patients, including those with sociodemographic challenges.

More than two-thirds of the star rating summary score is linked to outcome measures—mortality, readmission, and patient experience—all of which, research shows, are influenced by social risk factors. A large and growing body of evidence shows that sociodemographic factors—age, race, ethnicity, and language, for example—and socioeconomic status, such as income and education, can influence health outcomes.[6] These factors can skew results on certain outcome measures, such as those for readmissions. For measuring outcomes performance in the overall star ratings, **we strongly urge CMS to include methodology for calculating measures that incorporates risk adjustment for socioeconomic and sociodemographic factors,** so results are accurate and reflect varying patient characteristics across hospitals. Without proper risk adjustment, an essential hospital serving a disproportionate share of lower-income patients with compounding sociodemographic factors might receive a lower rating for reasons outside its control.

While America's Essential Hospitals supports including measures that cover multiple dimensions of quality, certain measures in the methodology—including those in the readmission group—are biased against essential hospitals. Risk adjusting measures for these factors will ensure patients receive accurate information about a hospital's performance. **America's Essential Hospitals urges CMS to include factors related to a patient's background, including sociodemographic status, language, and postdischarge support structure, in the risk-adjustment methodology for star ratings.**

Further, after receiving concerns from stakeholders that the Medicare Advantage star rating system creates a disincentive for plans to serve low-income beneficiaries or those dually eligible for Medicare and Medicaid, CMS risk adjusted a subset of star ratings

---

[5] See, e.g., National Quality Forum Technical Report. *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors.* August 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed March 14, 2019.
[6] 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 March 14, 2019.

measures for plans serving these vulnerable populations. Similarly, for clinicians who treat complex patients, CMS provides a bonus in their performance scoring under the Merit-based Incentive Payment System. **Looking to these examples, we urge CMS to devise ways to incorporate risk adjustment across programs, including hospital star ratings, and capture accurate hospital quality performance.**

   b.   <u>CMS should further examine approaches to comparing similar hospitals, while mitigating any unintended consequences, such as additional complexity for consumers.</u>

By virtue of essential hospitals' mission, they treat a disproportionate share of our nation's vulnerable and complex patients—both medically and socially. It is misleading to the consumer to portray all hospitals as being alike, with the same patient mix or services provided. We support CMS' efforts to address differences among hospitals in their ratings, as we have seen specialty hospitals often receive five stars, whereas major teaching hospitals, which have a substantially different patient mix and breadth of services, do not receive the same recognition. Further, the number of reported measures can impact ratings in ways unrelated to quality of care. Essential hospitals, reporting on larger numbers of star ratings measures, often are compared directly to hospitals performing far fewer procedures and that do not meet reporting thresholds for a majority of measures in the methodology.

CMS seeks input on calculating and presenting star ratings based on a "peer grouping" approach by which hospitals with a particular characteristic (e.g., teaching hospitals, safety-net hospitals, critical-access hospitals) could be compared and generate their own rating. **We support peer grouping as a short-term strategy on the way to true risk adjustment. Directionally, this is where the star ratings program should head: acknowledging and accounting for the differences in hospitals, unrelated to the quality of care they provide and that impact measure performance and ratings.**

Instituting peer grouping would raise issues of how to best display such information to the public, such as whether to replace the existing rating or supplement that score, in which case, patients would receive two scores for a hospital. Location (i.e., proximity to a provider) and insurance coverage often influence a patient's choice of care. With this in mind, coupled with the complexity that already exists in the star ratings system, it is difficult to assess whether including a secondary, peer-based metric would benefit consumers. **We urge CMS to examine the usefulness to the patient of having this information and options for its public display to ensure clear understanding and use by consumers.**

CMS already uses a peer-grouping approach in the Hospital Readmission Reduction Program (HRRP). The agency uses a stratified methodology to account for socioeconomic status, a provision of the fiscal year (FY) 2018 Inpatient Prospective Payment System final rule, in accordance with the 21st Century Cures Act. Under the new methodology, CMS will assess penalties for excess readmissions based on hospitals' performance compared with other hospitals that have similar proportions of dual-

eligible patients. The use of dual-eligibility as a variable for peer grouping in the star ratings should be examined further, along with other variables, such as number of measures reported. **We urge CMS to perform additional work to identify the variable or composite of variables by which peer grouping could be implemented and broadly share analyses or modeling of different approaches.**

We applaud the agency for recognizing that differences in hospitals matter when it comes to a ratings system. However, the provisions in the HRRP are but a first step toward true risk adjustment for hospitals treating patients with social and economic challenges. **The agency must go a step further and adjust measures so that quality comparisons are accurate and fair.** Risk adjustment at the measure level is even more important when those measures are used in other programs, such as the star ratings, and relied on by consumers.

4. **CMS should re-examine the underlying methodology of the star ratings to improve their reliability, predictability, and accuracy.**

A flawed methodology—not actual hospital performance—drives the star ratings. The underlying and complex statistical technique at the heart of the methodology lacks transparency and creates uncertainty by disproportionately and inconsistently weighting measures within groups. CMS uses a latent variable model (LVM) to calculate a numerical "loading factor" for each star ratings measure. The higher a measure's loading factor, the more it drives performance within a particular measure group.

As seen between the December 2017 release and previously planned July 2018 release, for the safety of care group, changes in the loading factors for the hip and knee complications measures and the PSI 90 composite measure led to dramatic shifts in performance, even though national performance changed very little. We applaud CMS' willingness to act (by postponing the July 2018 release) when it observed shifts in ratings that were "somewhat greater than expected given that there were no changes to the Overall Hospital Quality Star Rating methodology itself."

However, we believe the methodology, with its use of LVM, remains overly sensitive to subtle changes in the underlying data. This is problematic because it means a hospital's rating could hinge on measures that reflect only a narrow aspect of hospital care (e.g., hip/knee replacements), and that important, universal quality measures, such as the infection measures, might have almost no influence on the star rating. We observe this, in particular, within the safety of care group, in which the PSI 90 composite measure has a much larger loading than other measures. In other words, the methodology emphasizes the PSI 90 over other measures (e.g., the health care–associated infection measures). Whether intended or not, CMS is giving providers an unclear and inconsistent signal, based on flawed methodology, about where to focus their quality improvement efforts.

CMS seeks input on alternative approaches to LVM, such as an explicit approach, that assign weights to each measure in each group, independently of the performance distribution or relationships between measures. **The program would benefit from a simplified methodology, for better hospital and patient understanding.** An explicit approach warrants further evaluation and consideration to identify what challenges or unintended consequences might exist related to this approach. For example, if pre-assigned, differing weights are used in lieu of equal weights, stakeholders must come to a consensus on which measures to weigh more heavily.

Overall, the methodology for the star ratings should reflect true differences in quality and must ensure accuracy, reliability, and fairness. Further, patients should feel confident that the rating they use to make care choices truly reflect quality. **We urge CMS to examine an explicit approach to the star ratings calculations that will provide transparency and understanding to providers and patients.**

5. **CMS should take strategic steps to ensure confidence, by all stakeholders, in the star ratings program and the information it is intended to provide.**

Stability in the star ratings program is critical, for providers wanting to use the ratings to drive quality improvement and for patients making important health care choices based on these ratings.

     a. <u>CMS should refresh star ratings annually to improve stability and minimize period-to-period rating shifts.</u>

Under the biannual schedule for a refresh of the star ratings, subtle changes in the underlying data observed in a six-month period can change a rating, particularly for those hospitals with borderline scores. Further, the reporting schedule of individual measures varies, with some measures only refreshed annually. For example, the PSI 90 composite measure is updated annually in July. As such, **we urge CMS to transition to an annual refresh of star ratings, to ensure all measures refresh before each star rating calculation.**

     b. <u>CMS should seek impartial review of the star ratings methodology and broad stakeholder input.</u>

Independent, third-party review and analysis of the overall star rating methodology would enable CMS to adequately re-evaluate its methodology in an objective and transparent manner to ensure validity and appropriateness. Such a review could involve a consensus-based entity convening interested stakeholders and forming recommendations, based on those discussions, as to the future of the star ratings program. **We urge CMS to examine ways to validate its methodology and respond to shared stakeholder concerns.**

     c. <u>CMS should not publish star ratings until the agency appropriately resolves issues with the methodology.</u>

Any proposed changes to the methodology should avoid disproportionately disadvantaging any category of hospitals and ensure the ratings give patients meaningful and accurate hospital quality information. It is imperative that essential hospitals, as well as CMS, have adequate time to further understand proposed changes to the methodology and review the potential effects modifications might have on different types of hospitals. **We strongly urge CMS to refrain from publishing star ratings until it fully vets proposals and reaches stakeholder consensus.**

We stand ready to work with CMS and others on better ways to empower patients and their families with information about health care quality.

* * * * * * *

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Erin O'Malley, senior director of policy, at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO