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February 25, 2015

Patrick Conway, M.D.  
Deputy Administrator for Innovation & Quality  
Chief Medical Officer  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

***RE: Hospital Compare Star Ratings Public Comment Report #1 – Measure Selection for Hospital Star Ratings***

Dear Dr. Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the first report from the Centers for Medicare & Medicaid Services' (CMS) contractor tasked with developing a “star rating” system for the *Hospital Compare* website.

Similar to CMS's *Compare* websites for other health care facilities and Medicare Advantage plans, the agency intends eventually to give each hospital a single score from one to five stars – with five stars being best – by combining the scores of most *Hospital Compare* measures. CMS states that the use of star ratings would better align *Hospital Compare* with its other public reporting efforts, and improve the “usability and interpretability” of the website for patients and consumers by providing a single score reflecting “multiple dimensions of quality.” This first report proposes criteria for selecting the measures to include in a star rating; a second report providing a detailed scoring methodology is anticipated in spring 2015.

**America's hospitals were instrumental in the creation of *Hospital Compare* more than a decade ago, and remain strongly committed to sharing meaningful, accurate hospital quality information with the patients they serve. It is critical that such information is presented in an understandable manner.** Given the significant expansion in the number of publicly reported quality measures in CMS hospital programs, we understand the conceptual appeal of creating summary scores that would give patients a simplified, “at a glance” view of how hospitals perform on quality. A star rating system also is consistent with the trend to simplify ratings for not only health care facilities but also for a variety of other industries (e.g., hotels, restaurants).



**However, we question whether a single summary star rating will equip patients, families and communities with a meaningful, accurate picture of hospital quality that is relevant to their individual reasons for seeking care. Moreover, we are not confident that the measures available on *Hospital Compare* at this time will enable CMS to create a single, methodologically sound rating of all aspects of hospital quality. Therefore, as CMS continues to assess how best to implement a star rating system, we urge the agency to consider a star rating system in which it applies star ratings only to specific measure topics (e.g., heart attack care, patient experience).**

We outline the potential benefits of topical star ratings and the methodological pitfalls with using an overall star rating score below. We then comment on CMS's proposed measure selection criteria. The AHA also is engaged in discussions with hospital leaders across the country about the suitability of a star rating system, and looks forward to sharing additional input when CMS releases its second report in the spring.

#### **THE UTILITY OF TOPICAL STAR RATINGS**

**The AHA believes topical star ratings would be more helpful to patients than a single overall star rating.** Each individual patient's clinical diagnosis and circumstances are different, and the *Hospital Compare* quality measures most relevant to their care may differ. For instance, a patient undergoing an orthopedic procedure (e.g., a hip or knee replacement) may derive the greatest utility from measures reflecting a hospital's complication rates after such procedures, the occurrence of surgical site infections, and measures reflecting the steps hospitals take to minimize the risk of blood clots. However, a patient trying to decide where to give birth may be more interested in the hospital's rates of early elective deliveries. A hospital's readmission or mortality rate following heart attack would have little relevance to either of these patients, yet CMS would likely include such measures in an overall star rating. A topical star rating approach would provide patients with information on coherent sets of information relevant to their care.

We acknowledge that a few measures on *Hospital Compare* do reflect cross-cutting quality and safety efforts relevant to a broader patient population. For example, some infection data, like central-line associated blood stream infections, are relevant to many patient populations. Patients also would be interested to know the hospital's performance on the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey. CMS should consider how to display such cross-cutting performance data in conjunction with information on particular clinical topics.

#### **METHODOLOGICAL LIMITATIONS OF A SINGLE SUMMARY STAR RATING**

**The AHA is concerned that CMS may not be able to create a single, methodologically sound star rating of all aspects of hospital quality.** It is certainly possible to identify the most critical and salient measures of hospital quality for patients to consider and develop a way to roll

those up into a single overarching star rating of a hospital. However, CMS has not strategically chosen measures for inclusion on *Hospital Compare* with the intention of creating a single, comprehensive picture of the quality of hospital care. Instead, the agency has selected some measures because they were available, and included other measures because they meet the needs of a specific mandate, like the readmissions penalty program. As a result, the measures on *Hospital Compare* largely focus on important but relatively narrow aspects of hospital services like care for heart attack, stroke or pneumonia. There are only a small number of measures on *Hospital Compare* that reflect cross cutting issues affecting many patients. There also are important areas of quality and safety where good, reliable national standards are simply not yet available, such as medication safety. Since the agency has selected *Hospital Compare* measures in an inconsistent fashion, it is not clear that one can repurpose these data to create a fair and accurate overall assessment of the care delivered in hospitals.

We believe CMS is committed to making star ratings transparent, as demonstrated by the use of a technical expert panel (TEP) to advise on the work, and by its recent “dry run” of star ratings on the HCAHPS measures. These steps have helped hospitals to understand CMS’s early thinking on applying a star rating system. We look forward to providing additional comments when a full methodology is available.

#### **STAR RATING MEASURE SELECTION CRITERIA**

Our comments below pertain to nine proposed criteria for determining which measures should be included in a star rating. **While we question whether creating a single star rating is appropriate at this time, the AHA supports most of these criteria and believes they would apply equally well if the agency were to apply topical star ratings.**

Criterion #1 – Only measures with current measure scores publicly available on *Hospital Compare* should be included in Hospital Quality Star Ratings.

**The AHA supports this criterion.** The draft report suggests that star ratings should focus only on the measures available to the public that have not been delayed, suspended from reporting or retired from the inpatient quality reporting (IQR) or outpatient quality reporting (OQR) programs.

Criterion #2 – Hospital quality measure performance should be publicly reported prior to inclusion in star ratings.

**The AHA supports this criterion, but recommends that CMS include a specific amount of time for public reporting to occur, such as one year.** The draft report states that measures that are finalized for future IQR and OQR programs but not yet reported should be excluded from Star Rating to “ensure maximum transparency in the development and roll-out of a summary star rating.” A specific time period for public reporting would ensure the agency has sufficient time to identify any unintended consequences of collecting the measure.

Criterion #3 – Hospital quality measures with 100 or fewer hospitals reporting should not be included.

**The AHA supports this criterion.** The draft report suggests that six measures on *Hospital Compare* are reported by fewer than 100 hospitals, indicating they are not in broad use and, therefore, not relevant to a broad spectrum of patients and families.

Criterion #4 – Measures that solely assess participation in a clinical registry should not be included in star ratings.

**The AHA supports this criterion.** There are four measures on *Hospital Compare* that simply indicate whether a hospital has chosen to participate in a particular clinical registry, such as those for cardiac surgery and nursing sensitive care. However, comparing the results of these measures is difficult because not all hospitals report the same measures. Moreover, a recent study showed that simply participating in a clinical registry does not necessarily lead to better care outcomes.

Criterion #5 – Include in star ratings hospital quality measures that have been de-endorsed by the National Quality Forum (NQF) and received recommendation for retirement from the Measure Applications Partnership (MAP).

**The AHA strongly opposes this criterion.** CMS should use only NQF-endorsed, MAP-supported measures in its quality reporting programs. We fail to understand why CMS would include measures that do not meet these standards.

Criterion #6 – Exclude from star ratings structural measures that assess the use of a particular tool.

**The AHA supports this criterion.** Structural measures assess whether hospitals are implementing particular tools or interventions thought to be associated with higher quality or safer care. *Hospital Compare* currently includes three measures assessing whether hospitals are implementing a particular tool, like a safe surgery checklist, or the use of health information technology (HIT) to receive lab data. The draft report suggests there is wide variation in how these tools are used by hospitals, and limited evidence suggesting “their utilization is a stand-alone indication of quality care.”

Criterion #7 – Exclude from star ratings structural measures that assess hospital volume.

**The AHA supports this criterion.** There is one measure from the OQR program on *Hospital Compare* that assesses the volumes of various outpatient surgical procedures performed by hospitals. The draft report suggests that higher volumes are associated with better outcomes for some, but not all, surgical procedures. For these reasons, the report recommends excluding the measure from star ratings.

Criterion #8 – Include in star ratings measures that have been deemed “topped out” by CMS, the MAP or NQF as long as they are reported on *Hospital Compare*.

**The AHA supports this criterion.** There are 15 measures in the IQR and OQR programs that CMS, NQF or the MAP have identified as “topped out,” with little room for performance improvement. However, the report suggests that such measures may still provide useful information to patients, and would help identify “outlier” hospitals whose performance is particularly poor.

Criterion #9 – Include in star ratings cost and efficiency measures with “directional” measure results, and exclude “non-directional” measures where ideal performance is not known.

**The AHA supports this criterion, but urges CMS to address important underlying issues with many of its cost measures before including them in star ratings.** CMS reports two different types of efficiency and cost measures on *Hospital Compare*. Some measures do not have an “ideal” score or rate. For example, Medicare Spending per Beneficiary (MSPB) reports whether a hospital’s average Medicare spending in the three days prior to and 30 days following a hospital admission are the same as, above or below average. Other efficiency measures – like the OQR measures focused on the utilization rates of imaging procedures – have a “directional” score, in which a higher or lower rate is considered good performance. The report suggests that non-directional measures cannot be converted into a meaningful star rating, but that directional measures should be included in scores. We agree that hospitals should be focused on improving the “value” of care – that is, delivering the same or better outcomes at a lower cost. Hospitals need good measures of cost and resource use to assess value, and those measures should be coupled with information about quality so that providers are not blindly pushing towards the lowest possible cost.

However, many of the efficiency measures used on *Hospital Compare* lack NQF endorsement, providing little confidence that they reliably and accurately capture hospital performance. The agency should prioritize the selection of NQF-endorsed cost measures for future inclusion on *Hospital Compare*. Furthermore, we urge CMS to assess all cost and efficiency measures it intends to include in star ratings for the impact of sociodemographic factors, and to apply an adjustment if warranted. Sociodemographic adjustment is especially important to consider for any measure assessing cost performance in the period after hospital discharge since the availability of resources in communities to aid in patient recovery – and therefore help reduce the likelihood of utilizing expensive services – would likely affect hospital performance.

Thank you for the opportunity to comment. If you have questions, please contact me or Akin Demehin, AHA senior associate director for policy, at (202) 626-2365 or [ademehin@aha.org](mailto:ademehin@aha.org).

Sincerely,

/s/

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