



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

March 29, 2019

Kate Goodrich, MD  
Chief Medical Officer  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Transmitted via email to [cmsstarratings@yale.edu](mailto:cmsstarratings@yale.edu)

RE: Proposed Changes to Overall Hospital Quality Star Ratings Methodology

Dear Dr. Goodrich:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on proposed changes to the Overall Hospital Quality Star Ratings methodology.

CHA and our member hospitals continue to support making meaningful, transparent and actionable data available to consumers and providers. However, we continue to encounter challenges in understanding and explaining the Centers for Medicare & Medicaid Services (CMS) hospital five-star methodology to consumers and clinicians. California hospitals are subject to a variety of hospital ratings; in fact, we were the first in the country to have a star rating applied to hospital quality data and posted online (at [CalQualityCare.org](http://CalQualityCare.org)). Since the initial ratings were posted, several other organizations — including CMS — have released five-star ratings using varying methods, time periods, and measures. The growing number of five-star ratings for hospitals continues to confuse consumers and diverts hospital attention and resources from meaningful quality improvement efforts. These impacts are disproportionately felt by California's hospitals.

Hospitals agree that patients and families should have reliable and valid measures of the care provided by hospitals in their communities; this informs important and personal health care decisions. Unfortunately, we continue to believe that CMS' current methodology to publicly report an overall star rating for each hospital does not meet our shared goals. In addition, significant flaws in the star ratings methodology lead to inaccurate and misleading information.

CHA appreciates CMS' ongoing efforts to solicit stakeholder feedback on improving its approach to rating hospitals. CMS outlines several approaches to improving the star methodology in its document released in February 2019 for stakeholder feedback. After consulting with our member hospitals and health systems, we offer the following for consideration. Our comments are guided by our adopted principles for hospital ratings — and we welcome additional dialogue and discussion.

**First and foremost, we urge the agency to take a fresh look at the way in which patients and providers are currently using *Hospital Compare*, and whether proposed future changes in ratings methodologies meet those needs.** The research to date on health literacy and use of such tools tells us we have a long

way to go in providing patients with the information they are seeking, presented in a way that is understood. For example, we know that our patients are often seeking quality information on a condition-specific basis — such as mortality for a cardiac condition, or an infection or complication rate for a hip replacement — when “shopping” for their care. Providing these measures individually on *Hospital Compare* has been the hallmark of our collective transparency efforts and is where, we believe, patients find the most value. When aggregated to an overall hospital rating, the information becomes less useful and, in many instances, inappropriately characterizes the hospital’s quality of care.

Absent a complete rethinking of our approach to star ratings, **we believe that only three of CMS’ proposed methodological changes warrant additional consideration at this time. However, before pursuing any action, we urge CMS to consider additional stakeholder input from experts and put additional thought into our approach of hospital-specific ratings on clinical conditions as noted above.**

**CHA encourages the agency to carefully review the American Hospital Association’s comments, particularly how its analysis of each star ratings change proposed by CMS would address the six design elements outlined in their comments.** In discussions with California’s hospitals, the three areas outlined under that framework, noted below, have widespread support.

In the short term, CHA:

- Supports CMS’ proposed new clinical and empirical criteria for creating and maintaining star ratings measure groups. CMS would use a three-step approach: 1) an initial grouping based on clinical coherence; 2) a statistical “confirmatory factor analysis” that explores the extent to which there is a single factor that explains performance in the measure group; and 3) ongoing monitoring to ensure balance across the measures within the group.
- Agrees with CMS that the weights applied to the measures used in the latent variable models need to be revised. In particular, there is no reason to believe it is appropriate for the PSI-90 measures or the hospital-wide readmissions measure to be so disproportionately weighted in the calculation of star ratings such that they drown out the effect of other better — or at least equally good — measures in the safety and readmissions domains.
- Encourages CMS to continue exploring approaches to creating peer groups for star ratings as a short-term strategy to address the potential biases in star ratings. However, we also urge CMS to pursue further improvements to the risk adjustment approaches of its existing star ratings, as direct risk adjustment approaches may obviate the need for peer grouping in the future.

In the long term, CHA:

- Believes a less complex, “explicit” approach to scoring hospital star ratings may be the most promising option for improving star ratings. The current methodology has led to an inaccurate and potentially biased picture of hospital quality. In addition, the use of such a statistically intensive methodology makes the ratings of virtually no use to hospital quality improvement efforts and must be revisited.
- **Strongly opposes any approach to scoring hospitals on individual measures selected by patients to develop their own rating of a hospital. While conceptually we agree it seems the most consumer-friendly and obvious choice, the complexity of such an approach and opportunity for misleading information to be provided give us great pause.**
- Urges CMS to continue to revisit its current use of the PSI measure. We ask that the agency remove this measure from every public reporting program due to the measure’s challenges.

Dr. Kate Goodrich  
March 29, 2019

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CHA appreciates the opportunity to provide comments on the proposed changes and looks forward to continued engagement with CMS. If you have any questions, please do not hesitate to contact me at (202) 488-4688 or [akeefe@calhospital.org](mailto:akeefe@calhospital.org).

Sincerely,

/s/

Alyssa Keefe  
Vice President, Federal Regulatory Affairs

Attachment: CHA Guiding Principles on Publicly Released Hospital Quality Scorecards

**California Hospital Association**  
**Guiding Principles:**  
**Publicly Released Hospital Quality Scorecards**

November 2012

The California Hospital Association and its member hospitals support the appropriate collection, validation and dissemination of publicly reported hospital quality and patient safety information. Transparency of hospital quality data can improve patient outcomes by promoting collaboration among health care providers and enabling consumers and payers to make better informed health care choices.

Public disclosure of hospital quality metrics, often referred to as “scorecards,” has become a means of assessing, ranking and disseminating publicly reported information about health care providers. The California Hospital Association believes that the following set of core guiding principles should be considered:

**1. GENERAL CONSIDERATIONS:**

- a. Scorecards reflect only one source of available information to facilitate an understanding of the quality of health care delivery. They often serve as a good starting point for patients to ask more specific questions of their health care providers.
- b. Quality improvement is an iterative and continuous process. An assessment of the quality of hospital care represents a single snapshot in time, and should always use the most current available data. Even if the scorecard uses the most current available data, it will rarely represent present performance.

**2. MEANINGFUL DATA:**

- a. Scorecards typically include a combination of measure types - structure, process and outcomes. Outcome metrics, if appropriately determined, can be the most meaningful reflection of patient care.
- b. Publicly reported quality data included in the scorecard should be derived from an assessment of evidenced based quality measures that have been demonstrated to reliably assess meaningful aspects of patient care. The measures should be clinically and statistically confirmed, and relevant to the needs of health care consumers and providers. The National Quality Forum is a prominent organization that examines the reliability and validity of hospital quality measures.
- c. Reported measures should include clear descriptions of sample size and methodology, the time period reflected, and numerator/denominator definitions.
- d. Inclusion of condition specific measures is preferable. Aggregation of multiple measures into a single score for public release is not recommended because they typically

represent a combination of disparate metrics that are not actionable for consumer selection or provider performance improvement.

- e. While it is important that quality measures are feasible to collect, the construction of comparative quality measures using exclusively administrative (coded medical record) data remains challenging and results may be more indicative of documentation practices than actual delivery of care. When utilized, administrative data should incorporate all payer categories, rather than a single payer.

3. APPROPRIATE USE of RISK ADJUSTMENT :

- a. All scorecard data should be risk adjusted, using standardized, transparent statistical techniques that can be replicated. The scorecard needs to provide sufficient detail of both the measure construction and the risk adjustment methodology to be able to compare performance of specific procedures or clinical functions.

4. USE OF STANDARDIZED RATING FORMAT:

- a. The scorecard uses a basic standardized format, with explanations of symbols for presenting ratings, that facilitates comparison between hospitals' data without compromising accuracy.
- b. Ratings of hospitals based on cost or patient payment obligations should be separate and distinct from ratings based on clinical quality indicators.
- c. Ratings of hospitals based on patient assessment of the experience of care should be separate and distinct from ratings based on clinical quality indicators. In addition, for those hospitals that serve a disproportionate number of economically diverse patients, data should be further stratified to reflect socio-economic and cultural patient differences.

5. PROVIDER RECONCILIATION PERIOD:

- a. The organization developing the scorecard should, prior to public release of data, notify all hospitals included in the report and allow for a designated time period for hospitals to preview reports (a minimum of 30 days), and provide for necessary data corrections and comments. Those data corrections should be incorporated before the scorecard is release and include appropriate comments.

6. DISCLOSURE OF INFORMATION:

- a. The organization should disclose any challenges or deficiencies with the methods and/or data that were used to create the scorecard.
- b. The organization creating and releasing the scorecard and individuals providing expert opinion on behalf of the organization must disclose potential financial or non-financial conflicts of interest for the organization or the individuals with the release of the scorecard.

For questions, contact Alyssa Keefe, vice president of federal regulatory affairs, [akeefe@calhospital.org](mailto:akeefe@calhospital.org).