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Via Electronic Submission *(*cmsstarratings@lantanagroup.com)

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Kate Goodrich, M.D., M.H.S.
Director, Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Dr. Goodrich:

Re: **AAMC Comments on the Measure Selection for Hospital Compare Star Ratings TEP Report**

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the *Hospital Compare Star Ratings Public Comment Report #1: Measure Selection for Hospital Star Ratings*, which was prepared for the Centers for Medicare & Medicaid Services (CMS or Agency) based on the feedback from the Hospital Compare Star Ratings Technical Expert Panel (TEP or Panel). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans' Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

This report is the first part of a CMS multi-stage process to create a single summary quality score for hospitals. The Association appreciates the TEP's thoughtful approach on a measure selection framework, yet we are very concerned about the shift to a single rating system.

CMS Should Not Implement a Single 5-Star Composite Score for Each Hospital

The AAMC supports making more information accessible to patients and the public on Hospital Compare, but does not support the intention to create a single summary score for each hospital as this data can be misleading. We do not believe that a single score meets the needs of patients or providers for making health care decisions. This oversimplifies the complex factors that must be taken into account when assessing the value of the care quality. This is particularly true for the nation's teaching hospitals that typically care for sicker and more vulnerable patients in a diverse and complex environment.

Consumers utilizing Hospital Compare undoubtedly have a range of views as to which aspect of care is most relevant to their specific situation. The measures on Hospital Compare cover a wide variety of conditions and procedures in the inpatient, outpatient, and emergency department settings. Consumers may choose a hospital for a particular condition or location, and may make a different choice at another time. A rating that combines all of the multiple dimensional aspects into a single summary score may not be representative of the aspects of care that are truly important for each consumer.

In 2014, in conjunction with numerous stakeholders, the AAMC released a set of *Guiding Principles for Public Reporting of Provider Performance*,[1] which organized a set of guiding principles for public reporting into three broad categories: purpose, transparency, and validity. The Association believes CMS and the TEP should refer to these principles as they consider enhancements to Hospital Compare. One of the principles specifically addresses composite measures: "creating composites from disparate measures for ease of display should be avoided." Composites, particularly those that have not been reviewed by outside organizations, such as the NQF, may not meet the validity standards that a website like Hospital Compare should have. Consistent with this principle, the AAMC believes the Hospital Compare 5-star rating system should start with a subset of individual measures and should avoid creating new composite scores.

Feedback on Criteria for Measure Selection for Star Rating

In the report, the TEP broadly supported four criteria to guide consideration for measure star rating selection. This criteria includes the following:

1. Measures should be publicly reported
2. Measures should have current data reported
3. Measures should have a minimum of 100 hospitals reporting data, and
4. Measures should not solely assess participation in a clinical registry.

The Panel also debated five additional criteria that did not achieve broad consensus, which they are seeking feedback from CMS and the public. These additional criteria are described here:

5. Measures that have been de-endorsed by the National Quality Forum (NQF) and recommended for retirement by the Measures Applications Partnership (MAP) should be *included*
6. Structural measures that assess use of a particular tool should be *excluded*
7. Structural measures that assess volume should be *excluded*
8. Measures that have been deemed topped out should be *included*
9. Efficiency/cost measures:
    - Non-directional efficiency measures should be *excluded*
    - Directional efficiency measures be *included*

The AAMC supports most of the criteria outlined above, but believes the additional criteria should also be considered. In particular, CMS should phase-in the star ratings approach, starting with a subset of measures that are important to consumers and can be easily compared across various types of hospitals. In that regard, the AAMC recommends:

- **CMS should *exclude* all measures currently under review in the National Quality Forum (NQF) sociodemographic status (SDS) trial period.**
  This new criteria would exclude all readmission measures and potentially other measures influenced by SDS factors. The AAMC is concerned that the performance for these measures would be inaccurately portrayed without an appropriate SDS adjustment. In the recent *Advanced Notice of Methodological Changes for CY 2016 for Medicare Advantage (MA) Capitation Rates*,[2] CMS acknowledged that preliminary analyses "revealed both practical and statistically significant evidence of differential outcomes" for dual-eligible or low-income beneficiaries. To ensure that a

[1] AAMC Guiding Principles for Public Reporting located at www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf
[2] NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. February 20, 2015. http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf

similar bias does not occur in a star ratings system for hospitals, we ask that all measures under NQF SDS trial period be removed from consideration.

- **CMS should *exclude* patient safety indicator (PSI) measures from star ratings system.** There are currently two measures publicly reported on the Hospital Compare website: PSI-90 (complication/patient safety for selected indicators composite) and PSI-4 (death among surgical patients with serious treatable complications). These two measures utilize claims data to identify a clinical event, and are inadequately risk-adjusted to account for more complex patients. A recent Viewpoint article in the *Journal of the American Medical Association (JAMA)*[3] also noted the many deficiencies with PSI-90: flawed individual component measures, redundant conditions that are already being addressed in other hospital performance programs, and the overall inaccuracy of the adverse events identified by the measure, among other serious concerns. For these reasons, the AAMC recommends these measures not be included in the star rating system.

- **CMS should ***not* include measures that have been de-endorsed by the NQF and not recommended by the MAP (criterion #5).**
  NQF and MAP disapproval signals validity and reliability concerns with the measure methodology, and as noted by TEP members: "NQF de-endorsement (is) a strong statement that may be meaningful to patients and consumers." The rationale in the report for including these measures is "to ensure consistency and alignment in information presented to patients and consumers." As twenty-nine measures are already recommended for exclusion, the AAMC does not believe excluding a few additional measures will detract from consistency or alignment.

- **CMS should modify criterion #3 to exclude voluntary measures and to ensure that a large cross-section of hospitals are reporting the measure.**
  CMS should exclude voluntarily reported measures, regardless of the number of hospital reporting, because the measurement comparison may not be complete or representative. In addition, some measures are only reported by relatively few large hospitals, which again limits comparability of the measure. A hospital should not be disadvantaged if it reports a particular measure that others do not. For comparison purposes, the AAMC suggests all measures have sufficient variation in the types of hospitals reporting.

- **Other recommendations:**
  - Measures suspended by CMS should be *excluded* from consideration (including SCIP-Inf-4).
  - CMS has not updated "OP-22: ED – Patient Left without Being Seen" within the past 2 years. This measure should be *excluded* under criterion 2.
  - Do not include efficiency directional measures in the star ratings system at this time (criterion #9).

Additional Considerations for the Star Ratings

The Association asks CMS and the TEP to address the following methodological concerns as it moves forward in implementing a star ratings system.

- The comparison methodologies should be designed to remove the bias that occurs when comparing small hospitals to larger hospitals for certain measures. To achieve reliability, several

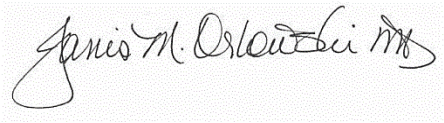
[3] Rajaram, Ravi, MD et al. "Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs." *JAMA*. 5 Feb. 2015 Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2109967

measure specifications stabilize small sample size by regressing to the national mean. This results in inherent differences when comparing performance for larger institutions (with larger sample size) to smaller institutions.

- Additionally, hospitals that have instituted a rigorous program to identify (and treat) infections are placed at a disadvantage when they are compared to those with less comprehensive quality programs. The TEP should consider ways to mitigate any misrepresentation of performance due to this type of surveillance bias.

Finally, the AAMC strongly urges CMS to further engage Hospital Compare users to ensure that any changes add additional value in understanding these measures and do not result in needless confusion. We also recommend implementing a process to allow providers to correct any errors in the display of this information. The AAMC thanks the Agency for considering these comments and looks forward to the TEP's future discussions on this topic. If you have any questions regarding these comments and recommendations, please contact Scott Wetzel (swetzel@aamc.org, 202-828-0495) or Mary Wheatley (mwheatley@aamc.org, 202-862-6297.)

Sincerely,



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Chief Health Care Officer

CC: Mary Wheatley, AAMC
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