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

August 27, 2015

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 Methodology of Overall Hospital Quality 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 #2: Methodology of Overall Hospital Quality 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 144 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 is the second and final report from CMS, which outlines the proposed scoring methodology that will be used to translate select measures (identified in report #1) into an overall hospital score for display on Hospital Compare. The AAMC appreciates the TEP's time and work on developing this process. However, we remain very concerned with the use of an untested overall star rating on Hospital Compare and believe it could be misleading to patients and their families. Many of these concerns were previously highlighted by the AAMC's comments[1] on the TEP's first report and are also outlined below.

An Overall Hospital Compare Composite Score Would Add to Confusion about Hospital Quality

The AAMC strongly supports making quality data available in an easy to understand format for patients and the public. The Association was a founding member of the Hospital Quality Alliance, which pushed hospitals to publicly report core process measures and later worked closely with CMS on the creation and development of the Hospital Compare website. While we support efforts for greater transparency, we believe that this information must be displayed in an appropriate fashion. A single composite rating that combines diverse quality measures, particularly those that lack clinical nuance, oversimplifies the complex factors that must be taken into account when assessing the value of the care quality. This is

[1] AAMC Comments on the Measure Selection for Hospital Compare Star Ratings TEP Report. 25 Feb. 2015 Retrieved here: https://www.aamc.org/download/425936/data/aamccommentletteroncmsstarratingstep.pdf

particularly true for the nation's teaching hospitals that typically care for sicker and more vulnerable patients in a diverse and complex environment. Moreover, the current methodology requires a certain percentage of hospitals in each of the 5 star levels. Therefore, even if all hospitals are improving and above a threshold of quality performance, there will always be those hospitals that fall into the one or two star category that may not be meaningfully different from those in a higher category.

The AAMC also disagrees with the assumption that creating a single quality score adds value to consumers. And as the AAMC states in the "Guiding Principles for Public Reporting of Provider Performance,"[2] one of the key parts of public reporting is having a clear purpose. The proposed star rating does not have a cohesive purpose other than to aggregate measures currently on the website. The new rating simply creates one more scoring methodology but does not add value to those that currently exist.

Rather than using a single composite score methodology, the AAMC recommends the development of star ratings for a subset of individual measures, which may ultimately be more meaningful and actionable for both consumers and providers. 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. Consumers utilizing the website should have the final say as to which aspect of care is most relevant to their specific situation. A rating that combines all of the multiple dimensional aspects into a single summary score may not provide a consumer with the information that is truly important for his or her situation. In the end, we are concerned that patients need multifacted information to aid them in their healthcare choices and that distilling a large amount of information into one overall star rating will not be useful.

The Composite Relies Heavily on Controversial Measures that Lack Clinical Accuracy or Sufficient Risk Adjustment

In the TEP's first report, 75 measures were selected for consideration into an overall composite. In the most recent proposed methodology, these measures were grouped into seven buckets, depending on type: outcomes-mortality, outcome-safety, outcome-readmissions, patient experience, process-effectiveness, process-timeliness, and efficiency-imaging. Each outcome and patient experience measure set was weighted higher at 22 percent and each process and efficiency measure set was weighted at 4 percent.

The AAMC is very concerned that the claims-based measures, which encompass all or parts of the mortality, safety, and readmissions groups, and are responsible for a significant percentage of an institution's overall star rating, do not capture the clinical nuances of the hospital's patient population. Claims-based data was developed for financial billing and reporting and was never intended to be used to assess quality within our nation's hospital. Use of this data for quality metrics rather than its original intent compromises the quality indicators. In the safety domain, the patient safety indicator composite (PSI-90) has been documented to be inconsistently coded or the coding is not reflective of the true clinical situation.[3] In addition the readmission measures have been correlated with sociodemographic status (SDS) factors that are beyond the immediate control of the hospital.[4] The policy considerations about SDS are so great that the National Quality Forum (NQF) is conducting a trial period to understand the

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[2] AAMC Guiding Principles for Public Reporting located at www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf

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

[4] *See*, Hu J, Gonsahn MD, Nerenz DR. Socioeconomic status and readmissions: evidence from an urban teaching hospital. *Health Aff (Millwood).* May 2014;33(5):778-785.

implications of adjusting (or not adjusting) certain accountability measures for these factors. In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting an evaluation on incorporating SDS into quality measurement. The high weighting of these measures in a composite could provide an inaccurate ranking.

In addition, these claims-based measures are highly correlated with the domain score. For example, the TEP report contained a breakdown of the measure's relationship to the overall group score relative to the other measures within the group, which is referred to as loading. Regarding the distribution of measures in the safety domain, performance on PSI-90 was clearly the measure most strongly associated with the group score. The AAMC is very concerned that the problematic PSI-90 measure has a much higher loading score than the Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN)'s measures. These measures, which are clinically validated, represented a much weaker association with the safety group score. This relationship is yet another reason to caution against creating a composite score.

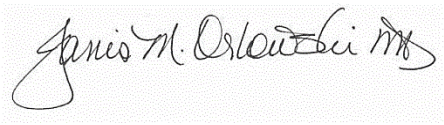
CMS Should Model the Effects of the Proposed Scoring Methodology by Hospital Characteristics to Identify Untended Consequences

CMS did not include a distribution of star ratings by hospital type using the methodology proposed in the second report. As with all other major policy changes, the AAMC requests that CMS make such an analysis publicly available so that stakeholders can determine whether any subgroup of hospitals are either disproportionately achieving higher or lower ratings under this methodology. Certain hospital types overwhelmingly rated as 4-5 stars or 1-2 stars would be an indicator that the proposed methodology does not work as intended.

Conclusion

The addition of an untested overall star rating measure is premature at this time. CMS should instead focus on improving the measures and measure display on Hospital Compare to reduce confusion. The AAMC thanks the Agency for considering these comments and looks forward to engaging on next steps. If you have any questions regarding these comments and recommendations, please contact Scott Wetzel (swetzel@aamc.org, 202-828-0495).

Sincerely,



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