

Overall Hospital Quality Star Ratings Public Input Verbatim Report I

Table 1. Overall Hospital Quality Star Ratings Public Input Period Verbatim Comments

| Date Posted | Measure Set or Measure        | Text of Comment  | Name, Credentials, and Organization of Commenter   | Email Address*   | Type of Organization * | Response*                          |
|-------------|-------------------------------|--|--|--|------------------------|------------------------------------|
| 2/28/2019   | Overall Project & Methodology | We have crowd sourced data from multiple hospitals and worked with health care quality leaders from around the country. We have openly presented and shared these findings directly with stakeholders at request. We are posting this with hopes of starting a respectful discussion around creating a fair, transparent and easy to understand ranking of hospitals that makes sense to consumer and providers. We believe the current system, as you will read below, is exceptionally complex. With complexity often comes unintended consequences. We are hopeful that a conversation can be had to foster continued improvement of our ranking systems. This is extremely important as physicians are being judged and society is drawing conclusions from those judgments that we do not believe are accurate. While we used the data primarily of Rush University in the heart of this analysis, we worked with colleagues from the University of Chicago, University of Virginia, and Wake Forest University to better understand the impact of this data. | Thomas Webb, MBA, Manager, Quality Improvement; Bala Hota, MD, Vice President, Chief Analytics Officer, Associate CMO, Associate CIO, Professor in Section of Infectious Diseases/Department of Medicine; Omar Lateef Stuart Levin, MD Presidential Professor of Rush University, Professor, Critical Care Medicine, Senior Vice President and Chief Medical Officer; Rush University Medical Center | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University     | Please refer to the Summary Report |

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| 2/28/2019   | Overall Project & Methodology | <p>As health care workers, we view quality care as a promise – to patients, to family of patients, and to the community. In this, we share a common goal with all participants in our healthcare system. At the federal level, many talented researchers and policy development leaders have designed systems to incentivize high quality care which contributes to a shared goal of a high-value healthcare system. At Rush University, we have sought to understand the connection of policy to the care we provide to our patients. We have found in our analyses that some unintended consequences may be resulting from the current national policies to measure healthcare quality. These findings align with some of the recent public debate over increased mortality being linked to readmission reduction programs. In our view, we are at a critical juncture in how we view hospital quality rating, and have a terrific opportunity to improve the way we measure hospital quality. In this letter, we will describe issues with the current CMS approach to measurement of hospital quality of care, as described by the CMS Stars rating and the Hospital Readmissions Reduction Program (HRRP). These issues arise from:</p> <ol style="list-style-type: none"> <li>1. Outlier patients, with frequent readmissions</li> <li>2. Adjustment of readmission scores based on hospital volume, and star rating effect</li> <li>3. Socioeconomic status adjustment</li> <li>4. Variability in ratings due to the Latent variable model.</li> </ol> | <p>Thomas Webb, MBA, Manager, Quality Improvement;<br/> Bala Hota, MD, Vice President, Chief Analytics Officer, Associate CMO, Associate CIO, Professor in Section of Infectious Diseases/Department of Medicine;<br/> Omar Lateef Stuart Levin, MD Presidential Professor of Rush University, Professor, Critical Care Medicine, Senior Vice President and Chief Medical Officer; Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University     | Please refer to the Summary Report |

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| 2/28/2019   | Overall Project & Methodology | <p>We believe the overall star rating, at this time, does not achieve the aim of a transparent measure of quality and safety that is easy to understand by consumers and healthcare quality leaders in hospitals. We also believe that those pushing for a refresh of these measures would rather wait for an accurate measure rather than one so dramatically affected by math as described above. Because of the cumulative effect of biases due to inadequate or inappropriate adjustment for socioeconomic status, hospital size, and outlier patients given heroic care, the star ratings inadvertently penalize large hospitals and academic medical centers. In academic arguments, these individual effects may be perceived as small. As we and other authors – including Bernheim, et al – have described, the effect of socioeconomic status on hospital measures is stronger than many chronic disease measures, and may account for more than a quarter of all hospitals changing rating. Heroic care, as we’ve shown, may adversely impact rating. Finally, simply being a large hospital may adversely affect rating and may have a financial penalty impact. These issues could be mitigated with four changes to the current star ratings and HRRP program. First, aligning adjustment for Socioeconomic status in the Stars program to that of the HRRP, would be a logical and consistent method for measuring quality. Second, capping the impact of volume on adjustment and incorporating confidence intervals would address issues with volume impacting rates. Third, removal of the impact of outlier readmissions on the readmission measure would eliminate the undue influence of individual patients on rates and, we speculate, reduce the risk of adverse outcomes due to unintended consequences of policy. Finally, abandoning the latent variable model in the composite rating for the Overall Rating would address its lack of consistency.</p> | <p>Thomas Webb, MBA, Manager, Quality Improvement;<br/> Bala Hota, MD, Vice President, Chief Analytics Officer, Associate CMO, Associate CIO, Professor in Section of Infectious Diseases/Department of Medicine;<br/> Omar Lateef Stuart Levin, MD Presidential Professor of Rush University, Professor, Critical Care Medicine, Senior Vice President and Chief Medical Officer;<br/> Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a>                         | Medical University     | Please refer to the Summary Report |
| 3/6/2019    | Overall Project & Methodology | <p>2. Simplify and decrease number of metrics. Very hard to have an effective strategy to address more than 15 major components.</p>  | <p>Patricia D. Boyette, MSHS, BSN, NE-BC Director, Operational Performance Improvement Corporate Quality, Orlando Health</p>   | <a href="mailto:Patricia.Boyette@orlandohealth.com">Patricia.Boyette@orlandohealth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/14/2019   | Overall Project & Methodology | <p>I am providing comments on behalf of Silver Cross Hospital, my contact information is below in my signature.</p> <p>I am commenting on the CMS Star Ratings program. I have extensively researched the program methodology, including the Latent Variable Model, Coefficient calculations, and Measure selection. I have also researched through literature and news articles on how many other organizations, including the American Hospital Association, have been commenting.</p> <p>Since many organizations have already commented extensively on the Latent Variable Model as well as weighting/loading criteria, I am deferring my comments in those particular areas to those organizations, since they have already clearly laid out their positions.</p> <p>I would like to add my comments in the category of Measurement Selection, namely:</p> | Assad Ghani MHSA, MBA, Director, Business Intelligence, Silver Cross Hospital | <a href="mailto:aghani@silvercross.org">aghani@silvercross.org</a> | Hospital               | Please refer to the Summary Report |
| 3/14/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>•Current measure alignment with other CMS programs – examples are Hospital Readmissions Penalty Program (HRRP) – is not sufficient within the current slate of Hospital Star Program measures.</li> <li>•Currently, there is disalignment between the Hospital Star Program in the Readmission Domain and the HRRP in terms of measurement selection. This makes it difficult to manage performance in an effective manner.</li> </ul>   | Assad Ghani MHSA, MBA, Director, Business Intelligence, Silver Cross Hospital | <a href="mailto:aghani@silvercross.org">aghani@silvercross.org</a> | Hospital               | Please refer to the Summary Report |
| 3/14/2019   | Overall Project & Methodology | Specifically, the Star program employs EDAC-PN, EDAC-AMI, EDAC-HF, Stroke, and Hospital-Wide All-Cause Readmissions, none of which are in the penalty program. We believe the Star program measurement selection should mirror what is already in place in the CMS HRRP program in order to better reflect improvement progress that has required years of time and resource investment.  | Assad Ghani MHSA, MBA, Director, Business Intelligence, Silver Cross Hospital | <a href="mailto:aghani@silvercross.org">aghani@silvercross.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/14/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>To use these measures in a Star program, CMS is not properly reflecting a Hospital's efforts in care improvement. The measures noted above (that are not part of the HRRP program) do not have mature measurement systems in place for hospitals to yet track. They are extremely important and should be reported, but they should be introduced in such a way as to allow ample time for a hospital to deploy improvement interventions. That is not the case with measures which are not in the HRRP program.</li> <li>We believe there should be consistency between CMS value programs (HRRP, HAC program, Value-Based Purchasing, HCAHPS Star Ratings) etc) and the Hospital Star ratings programs in terms of measurement selection, with deference to measures that are already in the those value programs, since they have been active for a longer period of time allowing hospitals to deploy improvement efforts.</li> </ul> <p>An appropriate assessment of hospital quality should correlate to a hospital's ability to improve rapidly, when some measurements are not part of a CMS program such as HRRP, HAC, or Value-Based Purchasing, it diminishes the consumer's ability to understand the strengths and weaknesses of a hospital.</p> | Assad Ghani MHSA, MBA, Director, Business Intelligence, Silver Cross Hospital | <a href="mailto:aghani@silvercross.org">aghani@silvercross.org</a> | Hospital              | Please refer to the Summary Report |

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| 3/14/2019   | Overall Project & Methodology | <p>On behalf of Henry Ford Health System (HFHS), I appreciate the opportunity to comment on aspects of the Overall Hospital Quality Star Rating system. HFHS thanks CMS for making this opportunity available to interested stakeholders. The Request document is remarkable for its frankness about current limitations of the Star Ratings, its clear and detailed presentation of possible alternatives that CMS and Yale/CORE have considered, and its apparent sincerity in seeking suggestions for improvement. HFHS looks forward to working with CMS and other stakeholders to improve the Star Rating system and making it more useful for both patients, hospitals, and other users.</p> <p>In the sections below, HFHS has offered responses to the specific questions listed in the Request document. I hope that these responses are taken in the spirit in which they are offered - as constructive suggestions designed to improve the clarity, transparency, accuracy, and value of a global hospital quality rating system.</p> <p>HFHS has, and has had all along, reservations about the value of a global hospital rating system. Given that hospital quality measures are largely uncorrelated with each other and that there are hundreds or even thousands of hospital quality measures that could be calculated, it would seem inevitable that ANY global rating system based on ANY subset of measures would have little or no predictive power for any one measure, or any set of measures, outside the set of those chosen. 1 Therefore, a patient seeking information on, say, quality of care for elective spine surgery, would not be able to use information from a global rating system based on other measures to make an informed decision.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/14/2019   | Overall Project & Methodology | <p>He/she would be better served by access to as many measures as possible on elective spine surgery specifically.</p> <p>Even for a patient seeking information on care that has some measures included in the global rating system, the global rating system will offer a picture of quality that is diluted and ill-focused because of the inclusion of measures irrelevant to his/her interest - again, because the other measures will not be correlated with the measures he/she cares most about and will therefore just be adding "noise" to the "signal" that he/she is looking for.</p> <p>Any global rating system, then, that selects a few measures in an environment with hundreds of potential measures all uncorrelated with each other, will end up with all hospitals looking more or less alike (and this may indeed be the true state of hospital quality). Developers can force greater separation of global scores by weighting schemes that give undue influence to a very small set of measures (e.g., PSI 90 in the Safety category), or by dividing the distribution into some number of categories, even if the differences between adjacent categories are not clinically meaningful.</p> <p>One concept that is important for judging hospital quality that is not included in the current Star Rating system is the concept of hospital capability. There are hospitals equipped and staffed to do heart transplants and hospitals that are not. There are hospitals whose orthopedic surgeons and Operating Room {OR} nurses are well-trained to do complex spine fusion procedures and hospitals whose surgeons and nurses are not. Poor-quality care may be a consequence of hospitals providing care (perhaps in emergency situations where it is justified) outside their usual scope of capability.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/14/2019   | Overall Project & Methodology | <p>To the extent this is true, patients making choices about hospitals may be better served by information about "capability" (perhaps as reflected in case or procedure volume) than by a mathematically complex Star Rating. Nevertheless, we understand and accept the purchaser and patient interest in a global Star Rating system and acknowledge that such a system will continue to exist and be used. Our primary interests are in accuracy, fairness, and transparency. HFHS offers the following suggestions, then, in the spirit of improving that system along those three major dimensions.</p> <p>' Hu. J, Jordan, J, Rubinfeld, I, Schreiber. M, Waterman, B, &amp; Ncrenz, DR. Correlations Among hospital quality measures: What Hospital Compare data tell us. American Journal of Medical Quality. 2017, Nov/Dec; JZ(6):U05 610. PMID:28693332.</p> <ul style="list-style-type: none"> <li>Should CMS use o "closed-form solution " or make technical changes like this potential solution and consider opportunities for such changes in the future?</li> </ul> <p>HFHS doesn't have a clear opinion on this issue, as it seems to be a highly technical issue whose pros and cons (beyond those stated in the Request document) can only be known to a few aficionados. Our lack of basis for an opinion, though, is just one example of the problem of lack of transparency in the current methodology.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |
| 3/14/2019   | Overall Project & Methodology | <p>If even people with advanced degrees in math or statistics or engineering can't understand or explain what is being done behind the curtain, then something is wrong. On this specific issue, it would seem like the more efficient and faster method would be preferred, and we are not confident that there would be any downside in terms of accuracy or fairness that would tip the argument the other way. The key problems with accuracy, fairness, and transparency lie in other issues that have already been discussed, like the latent variable modeling (LVM) method, weighting of measures within categories, and analytic methods like "quadrature" that are beyond the professional experience of essentially all interested stakeholders.</p>  | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |



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| 3/14/2019   | Overall Project & Methodology | Again, HFHS sincerely thanks CMS for the opportunity to offer suggestions on the Star Rating system. It should be possible to move to a system that is more transparent, more useful to consumers, and more useful to hospital staff working to improve quality than the system currently in place. We look forward to working with CMS on this task in any way that CMS would find useful. | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System                                    | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a>                         | Health System                          | Please refer to the Summary Report |
| 3/18/2019   | Overall Project & Methodology | Bravo to you for seeking input on making Hospital Compare more useful and representative.   | Vytas Kisieliuss, Chief Executive Officer, ReferWell  | <a href="mailto:vytas@referwell.com">vytas@referwell.com</a>               | Healthcare Performance Improvement Co. | Please refer to the Summary Report |
| 3/19/2019   | Overall Project & Methodology | Lastly, the RUSH University Medical Center research surrounding the STAR ratings is very revealing. This system MUST be changed quickly before it leads to more patient harm.   | Seger S. Morris, D.O., MBA, Hospitalist & Associate Clinical Professor of Internal Medicine, Magnolia Regional Health Center                | <a href="mailto:SMorris@mrhc.org">SMorris@mrhc.org</a>                     | Individual                             | Please refer to the Summary Report |
| 3/15/2019   | Overall Project & Methodology | As far as the comments to the methodology:<br>-would like to see a methodology similar to Truven/ Watson Top 100 hospitals.   | Kathy J. Nunemacher MSN, RN, CPN, CPHQ St. Luke's University Health Network Network Director Clinical Quality Data Governance and Reporting | <a href="mailto:Kathy.Nunemacher@sluhn.org">Kathy.Nunemacher@sluhn.org</a> | Individual                             | Please refer to the Summary Report |
| 3/20/2019   | Overall Project & Methodology | The group very much appreciated being asked for input and thought it was great that CMS was even asking.  | Leadership, Oregon State Health Insurance Assistance Program (SHIP)/Senior Health Insurance Benefits Assistance (SHIBA)                     | Forwarded by CMS leadership  | Purchaser                              | Please refer to the Summary Report |

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| 3/21/2019   | Overall Project & Methodology | This document is submitted in response to a request for public comment on the CMS Overall Hospital Quality Star Ratings. Please accept these comments on behalf of Sanford Health. Sanford Health is a fully integrated health system with 44 hospitals across the Midwest. Sanford hospitals included all five of the star ratings in the February 2019 release. Internally, we do not see that much variation reflected across other quality programs. Sanford does support making changes to the current methodology as reflected in the specific comments below. Comments are provided in relation to questions from each section of the CMS Public Input Request document. Sanford's comments appear in italics. Thank you for the opportunity to provide feedback.      | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health                  | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System          | Please refer to the Summary Report |
| 3/21/2019   | Overall Project & Methodology | The current Latent Variable Modeling (LVM) approach is not reliable and it is confusing to end-users. The changes CMS is proposing in regards to Measure Grouping, Period to Period Shifts, Incorporating Measure Precision and Annual Hospital Star Rating would only be valuable once the underlying concerns of the LVM are addressed. Until that time, there will still be the same swings in the data that is currently being seen.  | Elana Zuber, MBA<br>Quality Management System Program Manager<br>Oregon Health and Science University | <a href="mailto:matere@ohsu.edu">matere@ohsu.edu</a>   | Medical University     | Please refer to the Summary Report |
| 3/21/2019   | Overall Project & Methodology | Please keep and continue to improve CMS Stars, the Readmission Reduction Program, the HAC Reduction Program and VBP.<br>I have used Truven/Watson, US News and World Report, HealthGrades and Leapfrog to review and compare hospitals since they started. They didn't drive quality change for most hospitals.<br>Only when CMS became involved in Quality Measurement have hospitals begun to really become invested in improving the quality of care.<br>It's all new, and the programs will have faults and need constant improvement. But hospitals are finally focused on improving quality. I grew up in SE Michigan and while cars were stylish before 1970s, American auto companies didn't really focus on quality and safety until Honda and Toyota showed us how. | David Raymond, MPH, President,<br>Clinical Financial Management Associates, LLC                       | <a href="mailto:draymond@clinicalfinancial.com">draymond@clinicalfinancial.com</a>             | Individual             | Please refer to the Summary Report |

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| 3/22/2019   | Overall Project & Methodology | I am the Chief Nursing Officer for a community hospital in Wisconsin. We take pride in providing excellent service and quality to our patients. We watch our quality metrics closely in real time so we are not waiting for lagging data to respond and make improvements. We were awarded the Wisconsin Forward Award for Excellence which is based on the National Baldrige criteria in 2018 and finished the year at the 99th percentile for overall hospital ratings for HCAHPS. With these results, you can imagine our shock and disappointment to learn our star rating dropped for HCAHPS from a 5 star to a 4 star and our overall rating went from a 4 star to a 3 star. We spent several hours trying to find the cause of this drop and were unable to identify the specific cause. We are pleased that CMS is looking for feedback and would be happy to provide you with suggestions for improvement: | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a> | Hospital              | Please refer to the Summary Report |
| 3/22/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>• Provide feedback to the organization as why their score changed</li> <li>• Use real-time data since lagging data can paint an incorrect picture of current status</li> <li>• We also support WHA's recommendations listed below:</li> </ul>  | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a> | Hospital              | Please refer to the Summary Report |
| 3/22/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>○ "Recommend that CMS immediately suspend the star ratings for hospitals until updates to the calculation and reporting methods are done, such that:</li> <li>○ CMS engages an independent auditor to verify the updates have been applied correctly;</li> <li>○ CMS removes the Imaging Efficiency measure group;</li> <li>○ The calculations to the star ratings are transparent and replicable by hospitals; and</li> <li>○ The public and other stakeholders have been provided with education on the intent of the program.</li> </ul>  | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a> | Hospital              | Please refer to the Summary Report |

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| 3/25/2019   | Overall Project & Methodology | <p>Thank you for requesting input regarding the Overall Hospital Quality Star Rating on the Hospital Compare website. Benefis Health System appreciates the Centers for Medicare &amp; Medicaid Services' (CMS') efforts to revise the Overall Hospital Quality Star Rating system to more accurately assess outcomes, allow more appropriate comparisons of hospitals, and provide ratings that have value to consumers.</p> <p>As a not-for-profit health system with a 38,000 square mile service area in northcentral Montana, Benefis demonstrates an ongoing commitment to serving vulnerable populations by providing care to many low-income and uninsured patients. Benefis is the sole provider of many essential services in our region, including trauma care, air ambulance care, and intensive care. If the Star Rating methodology is improved, Benefis could utilize the Star Rating tool to inform us as we work to efficiently allocate our finite set of resources to meet the health and safety needs of our community and region.</p> | Greg Tierney, MD, Chief Medical Officer and Medical Group President, Benefis Health System         | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System          | Please refer to the Summary Report |
| 3/25/2019   | Overall Project & Methodology | In summary, given the hospital industry's outcry against the Star Rating system, combined with the lengthy and technical nature of CMS' recently issued report outlining significant potential changes to the system, Benefis urges CMS to remove the current Star Ratings from the Hospital Compare website and instead focus on implementing an improved system. If you have questions, please contact Julie Wall, Benefis Health System Vice President of Quality and Patient Safety, at (406) 455-5747 or juliewall@benefis.org.   | Greg Tierney, MD, Chief Medical Officer and Medical Group President, Benefis Health System         | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System          | Please refer to the Summary Report |
| 3/25/2019   | Overall Project & Methodology | <p>Thank you for the opportunity to submit comments on the above-captioned request for public input. Benefis Health System (BHS) appreciates the Centers for Medicare &amp; Medicaid Services' (CMS') work to revise the Overall Hospital Quality Star Rating methodology to allow more accurate comparisons of like hospitals, utilize metrics that more accurately assess quality outcomes, and provide a rating that has face value to both the hospital and consumer. Significant near term and future improvements will allow Benefis Health System to devote already scarce resources to more efficiently meet the health and safety needs of our community and region.</p> <p>As a not-for-profit, community owned hospital in northcentral Montana; the high cost of providing care to low income and uninsured patients leaves BHS with limited financial resources.</p>  | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System          | Please refer to the Summary Report |

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| 3/25/2019   | Overall Project & Methodology | Even with our limited means, Benefis demonstrates an ongoing commitment to serving vulnerable patients. Benefis Health System provides specialized services that our region otherwise would lack (e.g., trauma center, air ambulance, critical care); expands access with extensive outreach clinics; furnishes culturally appropriate care via our Native American Welcoming Center; provides housing for patients and families in our region who travel here for complex care; trains health care professionals; supplements social support services; and offers public health programs. Benefis Health System provides comprehensive ambulatory care through our hospital-based clinics that include onsite features—radiology and laboratory services, for example—not typically offered by freestanding physician offices. Our hospitals and clinics also offer behavioral health services, interpreters, and support programs for patients with complex medical and social needs. | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |
| 3/25/2019   | Overall Project & Methodology | For the future, CMS should move to a 1-3-5 star rating system   | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |

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| 3/25/2019   | Overall Project & Methodology | <p>In addition, a move to a 1-3-5 star scale could decrease the angst of hospitals who are near the edge of what is currently a “cluster”, and also have significant more face value to hospitals and consumers. A 1-3-5 star scale is simply more understandable and intuitive, as long as additional changes such as moving away from the LVM model and using predetermined measure weightings are implemented. In its simplest form:</p> <ul style="list-style-type: none"> <li>• 1-star: Hospital scores “worse than the nation” in statistically significantly more measures.</li> <li>• 3-Star: Hospital scores “same as the nation” in measures.</li> <li>• 5-star: Hospital scores “better than the nation” in statistically significantly more measures</li> </ul> <p>Given the fact that the Overall Hospital Quality Star Ratings were significantly delayed in being updated, and issued alongside an extremely lengthy and technical report and request for public input that considers significant changes to the methodology, BHS urges CMS to remove the current Overall Star Ratings from the CMS Hospital Compare website, and focus attention and resources on implementing a significantly improved star rating system. Feedback to CMS from hospitals such as BHS as well as national organizations representing the vast majority of hospitals in our nation, clearly shows consensus that the current Overall Hospital Star Ratings have no face value to healthcare providers or consumers. Explaining or rationalizing the current star ratings is taxing on hospital teams and leadership, and confusing to our patients.</p> | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System          | Please refer to the Summary Report |
| 3/25/2019   | Overall Project & Methodology | Hospitals and CMS must all focus our scarce resources on continually improving care and providing education and understandable data to consumers to empower them in their healthcare decision-making. The proposals in this 48 page request for public input are extremely technical and complex, and will take time to evaluate and implement. Benefis Health System appreciates CMS’ consideration of the many points and recommendations included in this response and we welcome the opportunity to work with CMS and others to significantly improve the Overall Hospital Star Ratings system as well as the CMS Hospital Compare website.   | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System          | Please refer to the Summary Report |

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| 3/25/2019   | Overall Project & Methodology | As a retired Nurse Practitioner and currently a Board member for Finger Lakes Health (FLH) in Geneva New York, I would like to provide feedback to you on the recently released CMS 5-Star ratings for hospitals. I have been extremely proud of our track record in many of the key patient safety and quality indicators, e.g. colonoscopy, acute MI, Stroke care and many others. And I acknowledge that we have work to do on improving our patients' and families' experience while in our care. | Ann McMullen   | <a href="mailto:jmcm@roadrunner.com">jmcm@roadrunner.com</a>                             | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.  | Sharon Johnson, MBA, CPHQ, CPPS, Director of Quality Management, Utilization Management and Patient Safety; Highland Hospital of Rochester | <a href="mailto:Sharon.Johnson@URMC.Rochester.edu">Sharon.Johnson@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | I believe that a responsible approach to the quality star ratings should be undertaken that will provide consumers with information that will accurately represent the quality and safety of care provided by hospitals. Due diligence should be given to development of appropriate measures and methodologies.  | Sharon Johnson, MBA, CPHQ, CPPS, Director of Quality Management, Utilization Management and Patient Safety; Highland Hospital of Rochester | <a href="mailto:Sharon.Johnson@URMC.Rochester.edu">Sharon.Johnson@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |

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| 3/26/2019   | Overall Project & Methodology | I have concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration. There is something fundamentally flawed about system in which the small community hospital with minimal services available is the highest rated hospital in our region and the academic medical centers and safety net hospitals look poor in comparison. I do not believe the STAR rating system helps consumers with serious life threatening conditions make informed decisions. The proposed changes are also a serious concern.                                      | Pat Reagan Webster, PhD CPPS, Associate Quality Officer; Strong Memorial Hospital; Associate Professor, Public Health Sciences; University of Rochester | <a href="mailto:patricia_reagan@urmc.rochester.edu">patricia_reagan@urmc.rochester.edu</a> | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | I am writing to register my comments and concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital   Quality Management Dept.                          | <a href="mailto:scrimet@amc.edu">scrimet@amc.edu</a>                                       | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | To whom it may concern,<br>I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.<br>Patient safety and quality have been my priorities since starting my nursing career as an nursing assistant over 30 years ago. The star rating as it is currently formatted does not provide an effective tool for demonstrating individual hospital quality and instead allows the comparison of hospitals that do not have inpatients with those that do.<br>Some changes that would improve the current system are: | Michele Walsh, MSN, RN, CNO; Ascension  | <a href="mailto:Michele.Walsh@ascension.org">Michele.Walsh@ascension.org</a>               | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | The Wisconsin Hospital Association is pleased to submit comments in response to the request for public input on current and proposed future methodology and ratings release updates.  | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association   | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                                     | Hospital Association   | Please refer to the Summary Report |



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| 3/26/2019   | Overall Project & Methodology | <p>On behalf of our more than 135-member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare &amp; Medicaid Services' (CMS) proposed methodology updates to the overall hospital quality star rating.</p> <p>According to the February 28, 2019 data refresh, Wisconsin had the highest average star score of any other state. The Agency for Healthcare Research and Quality (AHRQ) has ranked Wisconsin among the top four states in 11 of the past 12 years for providing high-quality health care delivery. Wisconsin hospitals outperform the national average in several health care associated infections, and our state's hospital patient experience survey data score higher than the national average, in every category where experience is surveyed.</p> | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | <p>WHA has a long history of public transparency and every hospital in the state voluntarily reports quality measures and summary ratings on a WHA website. We continue to support ratings that benefit the public and are useful to hospitals in driving their quality improvement work. That level of transparency and utility is lost in star ratings.</p>   | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/26/2019   | Overall Project & Methodology | <p>Further, because CMS intended to solicit public input to future changes to the calculation method and reporting schedule, CMS could have limited the refreshed ratings to hospitals and stakeholders in preview only, demonstrating the effect of the updated methodology, while simultaneously requesting comment. Payers and other stakeholders who use star ratings for reimbursement and other unintended purposes continue will continue to do so, basing their uses on ratings that are admittedly still in need of redesign.</p> <p>We recommend that <b>CMS immediately suspend the star ratings</b> for hospitals until updates to the calculation and reporting methods are done, such that:</p> <ul style="list-style-type: none"> <li>• CMS engages an independent auditor to verify the updates have been applied correctly;</li> <li>• CMS removes the Imaging Efficiency measure group;</li> <li>• The calculations to the star ratings are transparent and replicable by hospitals; and</li> <li>• The public and other stakeholders have been provided with education on the intent of the program.</li> </ul> <p>More specifically WHA is offering comment on the topics addressed in the request for input:</p> | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association  | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                                       | Hospital Association   | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | <p>WHA reiterates that health care quality improvement is best achieved through transparent, meaningful, and actionable data.</p> <p>We thank you for the opportunity to provide input and look forward to your thoughtful consideration of our comments. Should you have additional questions, please contact WHA's chief quality officer, Beth Dibbert at 608-274-1820 or <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>.</p>   | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association  | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                                       | Hospital Association   | Please refer to the Summary Report |
| 3/26/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.  | Kathy Parrinello PhD, Executive Vice President and COO; Strong Memorial Hospital, University of Rochester Medical Center | <a href="mailto:Kathy_Parrinello@URMC.Rochester.edu">Kathy_Parrinello@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | <p>I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration. I have spent many hours understanding the current measure selection and underlying statistical methodology both of which demonstrate opportunities for improvement. In particular, the use of latent variable modeling within the safety of care category which currently undermines the model itself and demonstrates a flawed use of this statistical analysis. Quality based ratings are certainly important and represent an area that should be better studied to fully understand how we categorize and advertise quality as well as how it is subsequently represented to our patients.</p> <p>To comment on some of the proposed changes I would agree with the current opinion of HANYS:</p>  | Daniel J. Baker, MD, MBA, Medical Director, Lenox Hill Hospital   | <a href="mailto:djbaker@northwell.edu">djbaker@northwell.edu</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | <p>On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input on potential future changes to the Centers for Medicare &amp; Medicaid Services (CMS) hospital overall star ratings system.</p> <p>As longstanding supporters of transparency, America’s hospitals and health systems believe that patients, families and communities should have valid, clear and meaningful quality information to help them make important health care decisions. That is why the AHA has strongly urged CMS to address the substantial flaws in the star ratings methodology since the ratings inception in 2016. We continue to be concerned that one of CMS’s laudable goals with star ratings – to give a meaningful, simplified view of hospital quality to consumers – is being compromised by a methodology that can lead to inaccurate, misleading comparisons of quality performance.</p> <p>The AHA appreciates CMS’s ongoing efforts to solicit stakeholder feedback on how to improve the ratings approach. The roughly one dozen potential changes to the star ratings methodology outlined in the request for comment attempt to address several important issues with star ratings and merit serious consideration.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>           | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | <p>However, the AHA believes that only three of the proposals should be pursued further at this time – empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and using an “explicit” scoring approach. The remaining proposals either fail to address important shortcomings with star ratings, or simply do not have enough information for us to judge their impact.</p> <p>The AHA also urges CMS to consider other steps to improve star ratings that are not addressed in the draft report. We believe it is important that these steps be taken prior to considering implementation of any other changes to the star ratings. Specifically, CMS should:</p> <ul style="list-style-type: none"> <li>-Engage a small group of experts on latent variable models (LVM) to ensure its calculation approach is executed correctly.</li> <li>- Examine how to mitigate the impact of outliers in calculating readmissions measures in the ratings.</li> <li>-Develop an alternative approach to star ratings in which, instead of an overall rating, hospitals receive ratings on specific clinical conditions or topic areas.</li> </ul> <p>Since CMS began work on overall star ratings in 2015, the AHA has repeatedly shared with the agency our ideas and concerns about the star ratings approach. In general, our concerns have asked CMS to address what we believe are six “must have” elements for the design of any star ratings system. These elements are described in greater detail below.</p> | Ashley Thompson,<br>Senior Vice President,<br>Public Policy and<br>Policy Development,<br>American Hospital<br>Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | <p>The attached table <a href="#">[Table 1]</a> provides the AHA’s assessment of the degree to which each star ratings change proposed by CMS would address the six design elements above. We would not expect that any single proposed change would address all of the “must have” elements and concerns that we have articulated. However, three of the suggested changes – empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and using an “explicit” scoring approach not tied to the LVM – appear to address partially at least three of these elements, and are worthy of further work by CMS. We comment briefly on each of these changes below</p> <p>Other proposed changes. As noted earlier, this letter’s attachment includes the AHA’s overall assessment of each of CMS’s proposed changes. While we will not provide detailed comments on each of them, we note concerns with two proposals. The AHA appreciates your consideration of these recommendations. We look forward to continuing to work with CMS to ensure star ratings achieve the goals of meaningfulness, accuracy and transparency that we and all stakeholders share. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, director of policy, at <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>                         | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.  | Karen Carey, Interfaith Medical Center  | <a href="mailto:KCarey@INTERFAITHMEDICAL.org">KCarey@INTERFAITHMEDICAL.org</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration. Thank you for your time.   | Kim Clement, Quality Analysis   | <a href="mailto:kclement@cmhhamilton.com">kclement@cmhhamilton.com</a>         | Individual             | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | <p>Lastly, we continue to urge CMS to remove the existing star ratings from Hospital Compare while its important work of improving the methodology continues. We appreciate the desire for the ratings to reflect the most current quality data. Yet CMS's public comment underscores the many problems with the current methodology. Unless and until the ratings methodology is improved, it will be difficult for hospitals and the public to have confidence that star ratings portray hospital performance accurately.</p> <p>Our comments below describe the elements that any approach to hospital star ratings must have in order to be a credible rating system. We then provide more detailed comments on the extent to which CMS's proposed changes address these elements, as well as comment on several other issues.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>                         | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Sean Fadale, FACHE President and CEO Community Memorial Hospital  | <a href="mailto:SFadale@Seancmh.hamilton.com">SFadale@Seancmh.hamilton.com</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Beth Falder, Health Quest   | <a href="mailto:bfalder@Health-quest.org">bfalder@Health-quest.org</a>         | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | <p>Working at a 21 bed, not-for-profit, community hospital, I wish to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.</p> <p>Small hospitals, such as the one I work in often do not have enough measures to apply which gives some domains an even higher disproportion of importance. Thank-you.</p>  | Kathleen M Hebdon, MSN, RN, CDE   | <a href="mailto:KHebdon@bch-jbr.org">KHebdon@bch-jbr.org</a>                   | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Amir K. Jaffer, MD, MBA Chief Medical Officer, New York Presbyterian Queens Hospital                        | <a href="mailto:ajaffer@nyp.org">ajaffer@nyp.org</a>                           | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Kurt Kodroff  | <a href="mailto:KKodroff@kingsbrook.org">KKodroff@kingsbrook.org</a>           | Individual             | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | Jaccel Kouns, MS, RN, NEA-BC, FACHE<br>Executive Director - Montefiore Mount Vernon<br>Vice President of Clinical Services | <a href="mailto:JKOUNS@montefiore.org">JKOUNS@montefiore.org</a>           | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.   | LuAnne Roberts   | <a href="mailto:lroberts@wcchs.net">lroberts@wcchs.net</a>                 | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | <p>I am writing on behalf of the University of California Health System, known as UC Health, to share our medical centers' concerns with the Hospital Compare quality metrics methodology that determines individual hospitals' Star Ratings. UC Health is comprised of five preeminent academic medical centers located at UC campuses in Davis, Irvine, Los Angeles, San Diego, and San Francisco. Each UC Health medical center fulfills the roles of being a tertiary or quaternary care provider and safety net provider. UC Health's medical centers provide a broad array of medical services, including, but not limited to: trauma services, burn care, organ transplants, and advanced stage cancer care. Our medical centers, along with the myriad primary and specialty care clinics that they operate, make up much of California's healthcare safety net. As many as 60 percent of the patients treated by UC Health System are publicly insured or uninsured.</p> <p>UC Health's medical centers continue to be ranked among the top medical centers in the country by many respected sources for the broad range of quality health care services they provide. We express great concern that the current Star Ratings methodology does not accurately reflect the heightened quality of care each of our medical centers provides. This is largely because the methodology fails to account for the vast array of medical services provided by UC Health's medical centers along with the high acuity patients and vulnerable patient populations our medical centers disproportionately serve.</p> | John Stobo, MD,<br>Executive Vice President, University of California Health System  | <a href="mailto:Julie.Clements@ucdavis.edu">Julie.Clements@ucdavis.edu</a> | Health System          | Please refer to the Summary Report |



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| 3/27/2019   | Overall Project & Methodology | We continue to doubt that the methodology informing current Star Ratings can fulfill CMS's intended goal of providing patients with reliable information upon which to make informed decisions about the selection of a hospital. We are grateful for this opportunity to provide CMS with feedback on our long-standing concerns with the Star Rating methodology, along with the agency's proposals concerning incorporating measure precision, frequency of Star Ratings reporting, peer grouping, and User-Customized Star Rating.  | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System         | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | Our Chief Medical Officers and Chief Nursing Officers regret that CMS did not consider the full impact of releasing updated Star Ratings to assessed hospitals before publishing them this past month to the broader public. The Star Rating methodology includes layers of analytic complexity that limit a healthcare system or individual clinician's ability to communicate the actual meaning of a Star Rating in a thoughtful and clinically relevant manner. We worry that patients may be unnecessarily frightened or confused by a hospital's Star Rating, when our UC Health medical centers have repeatedly proven, with the corroboration of countless, respected quality experts and quality assessments, that they are leaders in providing high quality medical care. Many UC Health patients necessitate tertiary and quaternary services for which there are either few or no other alternatives available. We believe that CMS should put into effect the following recommendations to ensure the Star Ratings methodology more accurately reflects the sophisticated, high quality care and more vulnerable patient populations commonly treated at UC Health's five academic medical centers. | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System         | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | Since the Hospital Compare Star Ratings system's inception, UC Health has sought to help inform the methodology CMS uses to assess hospitals' quality of care. We welcome ongoing discussions with the Yale quality experts tasked to review and revise the Star Ratings methodology. We do not believe the public can benefit from accessing CMS's Hospital Compare Star Ratings unless and until the methodology being used to evaluate hospitals more fully accounts for the distinct functions and patient populations characteristic of academic medical centers.  | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System         | Please refer to the Summary Report |



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| 3/27/2019   | Overall Project & Methodology | Thank you for the opportunity to respond to the Overall Hospital Quality Star Rating on Hospital Compare Public Input Request. Memorial Hermann is the largest not-for-profit healthcare system in Southeast Texas with 3,823 licensed beds, over 250,000 annual admissions and 500,000 Emergency Department visits. Memorial Hermann Health System would like to provide the following feedback:  | Angela A. Shippy, MD, FACP, FHM SVP & Chief Quality Officer<br>Memorial Hermann Health System | <a href="mailto:Angela.Shippy@memorialhermann.org">Angela.Shippy@memorialhermann.org</a> | Health System         | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | <p>The Missouri Hospital Association very much appreciates the opportunity to comment on potential updates and longer-term changes to the Overall Hospital Quality Star Ratings program and thanks the Centers for Medicare &amp; Medicaid Services for providing the opportunity to interested stakeholders. The Public Input Request document is notably forthcoming about current limitations of the Overall Hospital Star Ratings, several of which MHA previously has commented, and includes potential changes that reflect a clear evolution in thinking on the part of the measure developer regarding the potential benefits of a simpler, more transparent methodologic approach. We welcome this and, in the sections below, present responses to the specific questions posed in the Public Input Request document. We hope that our suggestions are useful in supporting CMS' efforts to improve the Star Rating system and make the system more useful for patients and other interested stakeholders.</p> <p>Review of our provided responses will reflect our general support for simpler, more transparent methodologies that fit the true dimensionality of targeted measures, while helping to ensure consumers are able to use them to fairly and meaningfully evaluate hospitals. We acknowledge the conceptual and methodologic challenges faced by developers that are inherent in the task of attempting to summarize the meaningful variation in the broad set of measures available on Hospital Compare into a single rating, and remain skeptical that this task truly is achievable in a manner that is both valid and fair.</p> | Herb B. Kuhn, President, CEO, Missouri Hospital Association                                   | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a>                               | Hospital Association  | Please refer to the Summary Report |

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| 3/27/2019   | Overall Project & Methodology | We also acknowledge our continued concerns we previously have voiced about the absence of necessary adjustment for social determinants in constituent measures included in the Overall Star Ratings — as shown in the attached letter to CMS Administrator Seema Verma — which we feel precludes fair and meaningful hospital comparisons, and thus effect the validity of the Star Ratings upon which they are based. We hope that MHA’s suggestions are taken in the spirit of our intent of supporting measure developers in achieving the stated objectives of the Star Ratings program in a manner that is empirically sound and clinically reasonable, while promoting reasonable accountability and meaningful quality improvement response by hospital stakeholders. | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association  | Please refer to the Summary Report |

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|-------------|-------------------------------|--|--|--|-----------------------|------------------------------------|
| 3/27/2019   | Overall Project & Methodology | <p>I am writing on behalf of Cook County Health (CCR) in response to the Centers for Medicare and Medicaid Services' (CMS) request for public input on the methodology behind the Overall Star Rating, the most recent iteration of which was published just last month. CCR is grateful for this opportunity to provide feedback into a complicated and controversial topic. We urge CMS to embrace some of the changes it is considering - namely, to rethink the latent variable modeling approach; to move toward a more explicit measure approach to modeling for more predictability and consistency; and to embrace peer groupings of hospitals to allow for fairer comparisons by potential users.</p> <p>About CCH</p> <p>Cook County Health (CCH) is one of the largest public health systems in the nation, serving the residents of the second most populous county in America. For over 180 years, CCR has provided care to all Cook County residents regardless of their ability to pay, insurance status, or immigration status. Patient services are delivered at our hospitals, regional outpatient centers, and community-based health centers located throughout Cook County; the busiest HIV center in the Midwest; and correctional health at the Cook County Jail and Juvenile Temporary Detention Center. CCR also includes the Cook County Department of Public Health, serving most of suburban Cook County, and CountyCare, the largest Medicaid managed care plan for Cook County Medicaid beneficiaries. CCR is the largest provider of care to uninsured and underinsured individuals in Illinois, providing \$500M in uncompensated care each year. As such, Cook County Health is uniquely positioned to appreciate the way in which this rule be harmful to patients and other residents of Cook County.</p> | John Jay Shannon, CEO, Cook County Health        | <a href="mailto:joshua.mark@cookcountyhhs.org">joshua.mark@cookcountyhhs.org</a> | Health System         | Please refer to the Summary Report |
| 3/27/2019   | Overall Project & Methodology | <p>Conclusion</p> <p>In the short term, CMS should rethink and adapt its latent variable model to make it more transparent and predictable. However, CCH believes that in the longer term, CMS should utilize a more stable and explicit measure approach that adjusts for patients' social determinants of health, coupled with hospital peer grouping. This should allow for the Hospital Star Rating to be more consistent and accurate.</p>  | John Jay Shannon, CEO, Cook County Health        | <a href="mailto:joshua.mark@cookcountyhhs.org">joshua.mark@cookcountyhhs.org</a> | Health System         | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure        | Text of Comment  | Name, Credentials, and Organization of Commenter  | Email Address*   | Type of Organization * | Response*                          |
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| 3/28/2019   | Overall Project & Methodology | <p>Overall STAR ratings do not seem to correlate with the individual measure results in presenting an overall hospital rating to the general public. The results in all categories for Adventist Health Lodi Memorial have been compiled below <a href="#">[Table 2]</a> as listed on the Hospital Compare website on 3/8/19. Areas where the hospital scored below/negatively in comparison to state/Nat'l average are in red. Several areas scored better than state/Nat'l.</p> <p>It's disturbing to see an overall rating of 2 (out of 5), when the hospital scores no different than or better than state/Nat'l in the majority of areas. The complex algorithm may arrive at these scores by various weighting calculations but it seems to be at variance with the individual measure calculations.</p>               | Brooke McCollough, MBA, Operations Executive, Adventist Health Lodi Memorial                      | <a href="mailto:Mccollb1@ah.org">Mccollb1@ah.org</a>                                       | Hospital               | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | <p>It also does not seem that the average citizen will go past the Overall Rating to see how a hospital performs in individual areas. Decisions may be made on the basis of the Overall STAR ratings. And since the Hospital Compare website is supposed to be for the average citizen to evaluate hospitals, this seems grossly skewed and an inaccurate representation of the overall care provided by a hospital.</p>   | Brooke McCollough, MBA, Operations Executive, Adventist Health Lodi Memorial                      | <a href="mailto:Mccollb1@ah.org">Mccollb1@ah.org</a>                                       | Hospital               | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | <p>Please blow up the current system!! It is flawed and it needs to be a simplified method for all to understand, including the public for which the ratings are intended for.</p> <p>I have been a nurse in my current role for over 21 years and this is the most frustrating rating system I have seen!</p>   | Marsha Ciolli, MSM- HC, BSN, RN, Vice President Quality Management, Terre Haute Regional Hospital | <a href="mailto:Marsha.Ciolli@HCAHealthcare.com">Marsha.Ciolli@HCAHealthcare.com</a>       | Individual             | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | <p>Nebraska Orthopaedic Hospital D.B.A. Ortho Nebraska Hospital would like to submit a comment regarding the methodology used to determine our Hospital Compare Overall Quality Star Rating. Our Hospital is currently not meeting the minimum data requirements for us to have a Star Rating, therefore our results display as 'N/A' on Hospital Compare. Which brings up two concerns; 1) How will the public interpret 'N/A' on Hospital Compare Overall Hospital Quality Star Rating? Our concern is the public will view this negatively as our facility did not participate or had a failing score. 2) This could affect our application to our insurance carriers for distinction programs and reimbursements. Ultimately, both of our concerns could affect future referrals, patient volumes and reimbursement.</p> | Christine Ellet, RN, MSN, CPHRM, Quality Manager, Ortho Nebraska Hospital                         | <a href="mailto:Christine.Ellett@OrthoNebraska.com">Christine.Ellett@OrthoNebraska.com</a> | Hospital               | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure        | Text of Comment  | Name, Credentials, and Organization of Commenter   | Email Address*   | Type of Organization * | Response*                          |
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| 3/28/2019   | Overall Project & Methodology | <p>We would appreciate any consideration in the future to account for hospitals that cannot meet measures due to size/volume and/or excelling in measures and thus not being considered for the Hospital Compare Overall Quality Star Rating. We take pride in our high-quality outcomes and this method of reporting does not reflect this accurately. If there is not the ability to change the methodology, we ask that there be something stated on the Hospital Compare site as to why a hospital would have a N/A rating.</p> <p>Thank you for the opportunity to provide comments.</p>  | Christine Ellet, RN, MSN, CPHRM, Quality Manager, Ortho Nebraska Hospital  | <a href="mailto:Christine.Ellett@OrthoNebraska.com">Christine.Ellett@OrthoNebraska.com</a> | Hospital               | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | <p>We appreciate the opportunity to comment on the overall hospital quality star ratings on Hospital Compare. As leaders of the Temple University Hospital and Temple Health, our views reflect our missions to serve our local community, to provide tertiary and quaternary care and to educate the next generation of providers . Temple University Hospital (TUH) has a major safety-net mission providing care for a significant proportion of patients in poverty in Philadelphia . At the same time, TUH offers an array of complex care including a Level I Trauma Center, a Bum Center, a Neonatal Intensive Care Unit as well as advanced cardiovascular, neurosurgical and transplantation services including the highest volume lung transplantation program in the country. TUH also serves as the major training hospital for the Lewis Katz School of Medicine at Temple University with a full array of residencies and fellowships.</p> | <p>Michael Young, MHA, President &amp; Chief Executive Officer, Temple University Hospital</p> <p>Henry Pitt, MD, Chief Quality Officer, Temple University Health System</p> | <a href="mailto:henry.pitt@tuhs.temple.edu">henry.pitt@tuhs.temple.edu</a>                 | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | <p>We appreciate your solicitation of our opinions and are confident that you will achieve a more equitable hospital star rating system as you respond to the needs of our patients and families.</p>  | <p>Michael Young, MHA, President &amp; Chief Executive Officer, Temple University Hospital</p> <p>Henry Pitt, MD, Chief Quality Officer, Temple University Health System</p> | <a href="mailto:henry.pitt@tuhs.temple.edu">henry.pitt@tuhs.temple.edu</a>                 | Health System          | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | <p>Some of the data are outdated and do not capture the true current state of a hospital's programs or services. Hospital systems review processes and practices to implement improvement efforts based on regulations, research, technology advancements and outcomes. The current methodology results in a negative hospital image (aka "scarlet letter") by various stakeholders, including the general public, prospective patients, competitors, insurance companies, the media, etc. This negative perception results in the hospital having to provide additional proof and data to defend the true metrics. This methodology misrepresents data and creates an irregular comparison to other institutions that do not submit similar measures and/or do not offer similar services.</p> <p>The Hospital Compare website indicates "No Difference" in measure after measure when comparing hospitals. When a CMS Star Rating is issued for a hospital, the rating does not calculate correctly (i.e., Patient Experience score is a three-star rating on Hospital Compare, but the Overall Hospital Quality Star Rating is a one-star). This current methodology creates a negative reflection on the hospital because prospective patients and other stakeholders do not have access to the expanded metrics that were factored into the ratings. Most of the data collected to produce a rating is old data and does not sync with other data timeframes. In addition, the calculations used for the measures are inconsistent. Some measures are risk-adjusted using a numerator/denominator, and other measures are not risk-adjusted.</p> | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | Stakeholders should be warned with a glaring disclaimer about the timeframe of data collected immediately upon reviewing the star rating. Every service line measured should also provide the stakeholder a more comprehensive explanation of how the star rating was calculated. The present CMS methodology uses old data to create misleading and unbalanced ratings which are not reflective of the current care provided.  | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System          | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | Another concern is that the CMS star rating system is currently inconsistent with other rating systems (e.g., Leapfrog, Healthgrades, US News and World Report). If an annual release occurs, CMS should review how other organizations provide the public with a scorecard that is easy for the public to comprehend.   | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Overall Project & Methodology | If CMS continues to issue the star rating, it should consider doing the following: 1) creating a website that is user-friendly, 2) hosting educational sessions to help hospitals understand how they can improve their scores and set achievable goals, and 3) developing an easy and transparent calculation that is reproducible for all organizations. Hospitals should be published with top decile/quartile results and provided benchmarks rather than dealing with results that cannot be reproduced (e.g., calculation of the rating for quality-based reimbursement equations is provided through HSCRC in advance of the measurement period so that personnel can evaluate the process concurrently). | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System          | Please refer to the Summary Report |

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| 3/28/19     | Overall Project & Methodology | <p>Alabama's hospitals are grateful to CMS for seeking input on the Hospital Star Ratings system. While we understand and support the goal of providing information to the public about their hospital care, we are gravely concerned that the current Star Rating system does more harm than good and should be significantly revised if not eliminated.</p> <p>Our Association has a monthly meeting for CEOs, quality and infection representatives, and many of these recent meetings have focused on the Star Rating system. Here are some of the concerns that have been expressed:</p> <ul style="list-style-type: none"> <li>• The rating system is far too complex and cannot be easily understood or explained to those who asked about the rating.</li> <li>• The performance measures aggregated into the overall star rating were not developed for this purpose and thus the factors that must be applied to them to try and bring reliability and equitable comparisons are well-intended, but don't necessarily work. For example, there are hospitals that have really good scores (zeroes in some cases on HACs) and yet these hospitals receive a score of "worse than expected" due to the methodology.</li> </ul> <p>The measures used for the ratings come from different time periods, making it difficult to know what measures affected the category scoring. In addition, many of the measures are older and thus it's difficult for improvements to have an effect on the score.</p> | Donald E. Williamson, MD, President/CEO; Alabama Hospital Association | <a href="mailto:rblackmon@alaha.org">rblackmon@alaha.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/28/19     | Overall Project & Methodology | <p>In general, we are concerned about trying to portray a hospital's quality performance with five simple stars. There are a number of our hospitals with three stars or less who provide great care, but due to a statistical calculation didn't score well. The current Hospital Compare database provides greater detail on the individual performance measures and thus a clearer picture of the quality of care provided. We would ask that CMS consider tweaking this information sharing platform to make it more user friendly in lieu of continuing to publish the overall Star Rating. However, if the overall ratings are continued in the future, we would request that the current ratings be taken offline while the new ratings are configured.</p> <p>Again, we are grateful that CMS understands that there are concerns with the rating system and we appreciate this opportunity to provide feedback.</p>  | Donald E. Williamson, MD, President/CEO; Alabama Hospital Association | <a href="mailto:rblackmon@alaha.org">rblackmon@alaha.org</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/28/2019   | Overall Project & Methodology | <p>Spectrum Health appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) request for public comment on several potential updates to and future considerations for the methodology of the Overall Hospital Quality Star Rating on Hospital Compare. Spectrum Health, a not-for-profit, integrated health system, is committed to improving the health and wellness of our communities. We live our mission every day with 31,000 compassionate professionals, 4,200 medical staff experts, 3,200 committed volunteers and a health plan serving 1 million members . Our talented physicians and caregivers are privileged to offer a full continuum of care and wellness services to our communities through 14 hospitals, including Helen DeVos Children's Hospital, 230 ambulatory sites and telehealth offerings. We pursue health care solutions for today and tomorrow that diversify our offerings. Locally-governed and based in Grand Rapids, Michigan, our health system provided \$483 million in community benefit in fiscal year 2018. Thanks to the generosity of our communities, we received \$30 million in philanthropy in the most recent fiscal year to support research, academics, innovation and clinical care. Spectrum Health has been recognized as one of the nation's 15 Top Health Systems by Truven Health Analytics®, part of IBM Watson Health™. As an integrated health system, we have prioritized for years the delivery of high-value care. It is with this system-wide commitment to value that we offer the following input on CMS' RFI.</p> <p>Overarching Comments</p> <p>We respectfully request that CMS use this RFI process to better analyze the impact of the star rating methodology on different types of hospitals, and provide more transparent information regarding the calculation of the ratings to determine accuracy.</p> | <p>Leslie M. Jurecko MD, MBA<br/>SVP, Quality, Safety, and Experience<br/>Spectrum Health<br/>Pediatric Hospitalist<br/>Assistant Professor of Pediatrics at Michigan State University,<br/>College of Human Medicine</p> | <p><a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a></p> | Hospital              | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | <p>Conclusion</p> <p>Thank you for consideration of our comments. We appreciate that CMS continues to seek input on changes to the Overall Hospital Quality Star Ratings on Hospital Compare. We remain committed to working with CMS on our shared goal of providing the public with accurate, purposeful, and timely information about quality.</p> | <p>Leslie M. Jurecko MD, MBA</p> <p>SVP, Quality, Safety, and Experience</p> <p>Spectrum Health</p> <p>Pediatric Hospitalist</p> <p>Assistant Professor of Pediatrics at Michigan State University, College of Human Medicine</p> | <a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a> | Hospital              | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | <p>The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the public input request to provide feedback on potential updates and future consideration for the methodology of the Overall Hospital Quality Star Rating on Hospital Compare, issued by the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.</p> <p>The AAMC appreciates the CMS dedication of future time and work on improving Star Ratings. We remain very concerned with the flawed methodology used to determine the Ratings posted on Hospital Compare and believe them to be both inaccurate and misleading to patients and consumers seeking hospital care. We urge CMS to continue to engage stakeholders throughout the Ratings improvement process.</p> <p>Summary of Key AAMC Recommendations</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | <p>Suspend the Star Ratings Until Flaws are Addressed</p> <p>The AAMC calls on the Administration to remove the publication of the Star Ratings from the Hospital Compare website until CMS is able to address significant concerns with the methodology. We request that prior to releasing Star Ratings, CMS take sufficient time to examine the feedback provided and make modifications to the methodology to ensure that the Ratings are accurate. We remain extremely concerned about potential consequences for patients that could result from an overly simplistic picture of hospital quality with a single overall rating. It is imperative that CMS contract with independent outside experts to review the methodology and verify its accuracy before public implementation. The AAMC also strongly recommends that CMS continue ongoing review for areas of improvement in future releases of the Ratings and convene stakeholders regularly to review the appropriateness of the current methodology.</p> <p>An Overall Hospital Compare Composite Rating Adds to Confusion About Hospital Quality</p> <p>The AAMC strongly supports making quality data available in an easy to understand format for patients and the public. While we support efforts for greater transparency, we believe that this information must be displayed in a meaningful fashion. A single composite rating that combines disparate quality measures, particularly those that lack clinical nuance, oversimplifies the complex factors that must be taken in account when assessing the care quality. The hospital star ratings are not a useful metric of overall quality of a hospital but a metric of a few discreet processes of questionable representation of overall quality and most importantly outcomes.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Overall Project & Methodology | <p>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.</p> <p>Rather than using a single composite score methodology, the AAMC recommends the development of Ratings for subsets of measures, which should ultimately be more meaningful and actionable for both patients and consumers, but also for the hospital’s quality improvement efforts. The measures on Hospital Compare cover a wide variety of conditions and procedures for the inpatient, outpatient, and emergency department settings yet under the current methodology only a handful of scores ultimately determine a hospital’s overall quality rating and compares hospitals regardless of the number of measures the hospital is scored on or services the hospital offers. A rating that combines all of the multiple dimensional aspects into a summary score may not provide a patient or consumers with the information that is truly important for an individual’s situation. Even worse, the current system does not shine light on the differences between hospitals compared or disclose the areas where a given hospital might not provide a given service or may lack a measure score. Patients may choose a hospital for a particular condition or location at one time, and may make a different choice at another time and should have better access to quality information to inform those choices. We are concerned that patients lack the multifaceted information they need to aid them in their healthcare choices. Distilling a large amount of information into one overall rating is not useful.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.orgpr">galee@aamc.orgpr</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>Advocate Aurora Health (Advocate Aurora) appreciates the opportunity to comment on the public input request to provide feedback on potential updates and future consideration for the methodology of the Overall Hospital Quality Star Rating on Hospital Compare, issued by the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>We want to commend CMS for your time and commitment to improve star ratings but we remain very concerned with the flawed methodology used to determine the ratings posted on Hospital Compare and believe them to be both inaccurate and misleading to patients and consumers seeking hospital care. <b>We do not feel CMS has addressed the major concerns about the methodology and usefulness of the star ratings and urge CMS to continue to engage stakeholders throughout the Ratings improvement process.</b></p> <p><b><u>Advocate Aurora Overview</u></b></p> <p>Advocate Aurora is the 10th largest not-for-profit, integrated health system in the United States and a leading employer in the Midwest with more than 70,000 employees, including more than 8,100 physicians and 22,000 nurses and the region’s largest employed medical staff and home health organization. A national leader in clinical innovation, health outcomes, consumer experience, and value-based care, the system serves nearly 3 million patients annually in Illinois and Wisconsin across more than 500 sites of care. Advocate Aurora is engaged in hundreds of clinical trials and research studies and is nationally recognized for its expertise in cardiology, neurosciences, oncology, and pediatrics.</p> | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora<br>Health | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System         | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>Our newly-formed organization is proud to be a national leader in testing and implementing innovative payment and care delivery models and stands ready to work with federal policymakers to advance efforts to improve care quality and outcomes, while reducing costs. Advocate Aurora has a strong track record of innovation in health care delivery and demonstrated success in the Medicare Shared Savings Program. Both legacy organizations, Advocate Health Care (Advocate) and Aurora Health Care (Aurora), have been trailblazers in the journey to value. Advocate was one of the nation’s first health systems to establish a clinical integration program and through that groundbreaking platform helped lead the nation in health care innovation and delivery reform. Advocate Aurora leaders – and others from our peer organizations – are eager to bring their expertise and experience forward to inform public and private sector efforts to increase innovation and investment in the health care sector so that individuals, families, communities, and the nation can experience better health outcomes, reduced costs, and improved efficiencies in our system of care.</p> <p><b>Summary of Advocate Aurora Recommendations</b><br/> The following are Advocate Aurora’s key recommendations on methodologic improvements:</p> <p><b>1. Suspend the Star Ratings:</b> CMS should remove the publication of the star ratings from the <i>Hospital Compare</i> website until CMS is able to address significant concerns with the methodology.</p> | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Thank you for your consideration of our comments below.</p> <p><b>1. Suspend the Star Ratings</b><br/> Advocate Aurora calls on the Administration to remove the publication of the star ratings from the Hospital Compare website until CMS can address significant concerns with the methodology. We request that prior to releasing star ratings, CMS take sufficient time to examine the feedback provided and make modifications to the methodology to ensure that the Ratings are accurate. We remain very concerned about potential consequences for patients that could result from decisions made using an overly simplistic picture of hospital quality with a single overall rating.</p>   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p><b>Conclusion</b></p> <p>Again, we thank you for the opportunity to provide our feedback. Advocate Aurora remains committed to working with CMS on our shared goal – providing the public with accurate, purposeful information about quality. We stand ready to be a resource to the Agency as you work to improving the star ratings. Please do not hesitate to contact Meghan Woltman, Vice President, Government and Community Relations (630/929-6614, Meghan.Woltman@AdvocateHealth.com) should you have any questions or if we can be of any assistance.</p>   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a>   | Health System          | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Thank you for the allowing Harris Health System to provide comment on the Overall Hospital Quality Star Rating program. Harris Health System is a fully integrated healthcare system that cares for all residents of Harris County, Texas. As a Safety Net organization for the nation's third largest county, we provide services in 18 community health centers, five same-day clinics, five school-based clinics, three multi-specialty clinic locations, a dental center, a dialysis center, mobile health units, and two full- service hospitals. We are the first accredited healthcare institution in Harris County to be designated by the National Committee for Quality Assurance as a Patient-Centered Medical Home, and are one of the largest systems in the country to achieve the quality standard. In Fiscal Year 2018 the Harris Health System provided \$651 million in charity care and 60.2% of our payor mix was uninsured.</p> <p>Harris Health System supports sharing important hospital quality information with patients and our community. Nevertheless, we believe there is an inherent risk for hospitals providing care to a high proportion of low-income patients, teaching hospitals, and larger hospitals to be scored with much lower star ratings despite providing high quality care, frequently to the most vulnerable patients. We request that CMS cease publication of the ratings and take the following comments into consideration:</p> | George V. Masi,<br>President and CEO;<br>Harris Health System                | <a href="mailto:Elizabeth.Greenlee@harrishealth.org">Elizabeth.Greenlee@harrishealth.org</a> | Health System          | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | Harris Health System implores CMS to refrain from publishing future star ratings until such a time as key stakeholders can agree upon appropriate risk adjustment, a clearer methodology for reporting data, and a stratified reporting structure that does not penalize safety net organizations such as ours.  | George V. Masi,<br>President and CEO;<br>Harris Health System                | <a href="mailto:Elizabeth.Greenlee@harrishealth.org">Elizabeth.Greenlee@harrishealth.org</a> | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>Beaumont Health appreciates the opportunity to comment on the public input request to provide feedback on potential updates and future consideration for the methodology of the Overall Hospital Quality Star Rating on <i>Hospital Compare</i>, issued by the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>Beaumont Health is Michigan’s largest health care system and we pride ourselves on being most preferred for health care in Southeast Michigan. Beaumont Health is a not-for-profit health system created to provide patients with greater access to compassionate, extraordinary care, every day. Beaumont consists of eight hospitals with 3,429 beds, 145 outpatient sites, nearly 5,000 physicians, 38,000 employees and 3,500 volunteers. In 2018, Beaumont had 178,196 inpatient discharges, 17,790 births and 572,597 emergency visits. All eight Beaumont Hospitals host Graduate Medical Education (GME) programs and our system serves as one of the top producers of physicians in Michigan.</p> <p>Beaumont Health appreciates CMS’ dedication to improving star ratings and the time and work that has been dedicated to this issue. We have long supported transparency on quality and safety data. In fact, the practice is directly correlated with Beaumont Health’s dedication to patient-centered care and ensuring our patients and their families have clear, useful information to make important health care decisions.</p> <p>However, Beaumont Health remains concerned with CMS’ approach to star ratings and the methodology currently utilized. We stand by the positions of the American Hospital Association (AHA) and the Association of American Medical Colleges (AAMC) and urge CMS to improve upon existing measures in hospital quality reporting and performance programs while also undertaking efforts to update and improve the star rating methodology.</p> | Mary A. Zatina, Senior Vice President, Government Relations and Community Affairs; Beaumont Health | <a href="mailto:Megan.Blue@beaumont.org">Megan.Blue@beaumont.org</a> | Health Care System    | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Beaumont Health supports making quality data available in an easy-to-understand and accessible fashion for patients. Yet, we are concerned as to how this information is presented and displayed. A single rating combining diverse quality measures oversimplifies the complex factors that must be considered to provide an accurate quality perception. Especially since some of these factors lack a clinical nuance. By utilizing this oversimplified approach, the information displayed is misleading and can have consequences for patients trying to properly assess their care options.</p> <p>We appreciate the opportunity to continue a dialog on this issue and request CMS postpone the publication of updates until concerns regarding methodology can be remedied through continued conversation. Furthermore, we request that prior to releasing star ratings, CMS take sufficient time to examine the feedback provided and make modifications to the methodology to ensure that ratings are accurate. Without these measures, Beaumont Health remains concerned about potential consequences for patients resulting from an overly simplistic picture of hospital quality with a single overall rating.</p> <p>Beaumont Health remains committed to working alongside CMS and other stakeholders to address concerns raised about the current star ratings model and potential changes/improvements down the line. We thank you again for the opportunity to voice these concerns and welcome continued dialog.</p> | Mary A. Zatina, Senior Vice President, Government Relations and Community Affairs; Beaumont Health | <a href="mailto:Megan.Blue@beaumont.org">Megan.Blue@beaumont.org</a> | Health Care System     | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Cleveland Clinic (CC) is a not-for-profit, integrated healthcare system dedicated to patient care, teaching, and research. Our health system is comprised of a main campus, 10 community hospitals, and 21 family health centers with over 3,500 salaried physicians and scientists. Last year, our system had more than seven million patient visits and over 220,000 hospital admissions.</p> <p>Cleveland Clinic appreciates CMS' consideration of public input in its efforts to improve the hospital ratings methodology. We are taking this opportunity to provide our comments:</p>  | Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic                           | <a href="mailto:deylingc@ccf.org">deylingc@ccf.org</a>               | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Thank you for conducting a thoughtful process that allows us to provide input on such important issues and for your consideration of this information. Should you need any further information, please don't hesitate to contact us.</p>  | Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic                           | <a href="mailto:deylingc@ccf.org">deylingc@ccf.org</a>               | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>On behalf of Johns Hopkins Medicine (JHM), thank you for the opportunity to comment on the proposed changes to the CMS Overall Quality Hospital Star Rating system. We support efforts to develop consumer-oriented tools designed to make quality information easier for patients and others to understand and compare, but have serious concerns about the validity of the current hospital star ratings methodology. CMS should remove the Overall Quality Hospital star ratings from the Hospital Compare website until it addresses significant methodologic flaws that render the current ratings inaccurate and misleading to patients.</p> <p>JHM is the umbrella entity that unites the physicians and scientists of The Johns Hopkins University School of Medicine with the health professionals and facilities of The Johns Hopkins Health System, an integrated system of six academic and community hospitals, four suburban health care and surgery centers, and more than 40 patient care locations in the Baltimore Washington region and Florida. JHM also includes The Johns Hopkins Armstrong Institute for Patient Safety and Quality, which is a national leader in quality measurement and improvement.</p> | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a> | Health Organization   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>The flagship of the system, The Johns Hopkins Hospital, is a leading academic health care system in the United States. Like many large academic medical centers, it treats a high proportion of complex, vulnerable, and low-income patients, many of whom require highly specialized care.</p> <p>We recognize that no rating system is perfect and the science of performance measurement is still maturing. As such, we appreciate the opportunity to provide feedback on our long-standing concerns with the underlying methodology, measure weights/grouping, and the need to adjust for socio-economic status of patients. For your consideration, we offer some reflections on the proposed short-term changes to the CMS Overall Quality Hospital Star ratings:</p>  | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a> | Health Organization   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>We appreciate the opportunity to comment on these proposed changes to the Overall Quality Hospital Star Ratings. In our shared commitment to finding better ways of sharing hospital quality data with patients and communities, we would be more than happy to discuss any of these comments and recommendations in greater detail.</p>   | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a> | Health Organization   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>On behalf of our member nonprofit and public hospitals and other healthcare providers, the Healthcare Association of New York State appreciates the opportunity to comment on the possible updates to and future considerations for the Overall Hospital Quality Star Ratings methodology.</p> <p>While HANYS supports the public availability of hospital quality data, we have concerns about CMS' Overall Hospital Quality Star Ratings approach, which oversimplifies the complexity of delivering high-quality care, uses flawed measures and fails to adjust for complex patients' medical conditions and sociodemographic factors that impact outcomes.</p>  | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Given the many flaws in the methodology and the unclear impact of the proposed changes, HANYS strongly urges CMS to remove the Star Ratings from the Hospital Compare website. We request that CMS allow sufficient time to examine feedback provided and make significant modifications to the methodology to ensure that the Star Ratings are accurate before publishing them. In addition to gathering these comments, HANYS urges CMS to proceed with ongoing methodology transparency, seeking stakeholder feedback in advance of public reporting for each version change.</p> <p>In general, Hospital Compare provides helpful information for patients and communities about hospital quality of care. It provides detailed information at the individual quality measure level, including measure definitions, measure rationale, data reporting periods, national benchmarks, hospital performance and instructions for how to read the performance score. Measure-level information enables patients and family members to look into the specific aspects of care that are most relevant to their medical conditions and healthcare needs.</p> <p>However, the Star Ratings combine numerous quality measures from different timeframes, settings and measure groups into one single rating. The composite Star Ratings create unnecessary complexity. Patients and families do not possess the clinical and statistical knowledge or the time needed to decode the Star Ratings and to extract the information that is most relevant to them. Moreover, they should not be expected to do so.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The composite Star Ratings also do not provide actionable information for hospitals to identify opportunities for improvement. The confounding effects of numerous measures based on data from different timeframes, settings and with varying impact, make it extremely difficult to effectively isolate current and relevant performance issues.</p> <p>The Star Ratings fail to genuinely reflect hospital quality performance and are inconsistent with the trends shown in other national and state quality efforts and pay-for-performance programs. For example, the Star Ratings use the Patient Safety and Adverse Events Composite (PSI-90), a highly flawed quality measure that does not discriminate among events and fails to accurately capture what is intended. PSI-90 drives nearly all of the performance in the Outcome: Safety domain.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>The composite Star Ratings also do not provide actionable information for hospitals to identify opportunities for improvement. The confounding effects of numerous measures based on data from different timeframes, settings and with varying impact, make it extremely difficult to effectively isolate current and relevant performance issues.</p> <p>The Star Ratings fail to genuinely reflect hospital quality performance and are inconsistent with the trends shown in other national and state quality efforts and pay-for-performance programs. For example, the Star Ratings use the Patient Safety and Adverse Events Composite (PSI-90), a highly flawed quality measure that does not discriminate among events and fails to accurately capture what is intended. PSI-90 drives nearly all of the performance in the Outcome: Safety domain.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Comments on specific proposed changes</p> <p>As stated above, we have significant concerns with the Overall Hospital Quality Star Ratings. CMS requested feedback on possible enhancements for the Star Ratings methodology; below are HANYS' specific comments in response to that request.</p>  | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure        | Text of Comment   | Name, Credentials, and Organization of Commenter                                   | Email Address*   | Type of Organization* | Response*                          |
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| 3/29/2019   | Overall Project & Methodology | <p>On behalf of the patients and staff of Tampa General Hospital (TGH) we appreciate the opportunity to comment on potential changes to the Overall Hospital Quality Star Rating on Hospital Compare. TGH appreciates and supports the Centers for Medicare &amp; Medicaid Services' (CMS) work to improve the delivery of high-quality health care across the health care continuum. Tampa General Hospital, with over 1,000 licensed beds is one of the most comprehensive medical facilities in Florida serving over 1 dozen counties with a population of more than 4 million. We are the area's only level 1 trauma center and the region's leading safety net hospital, committed to providing quality health care to all patients regardless of ability to pay. Our hospital is home to one of the largest organ transplant centers in the country, having performed over 10,000 adult solid organs transplants. We are a nationally certified comprehensive stroke center and offer other nationally recognized services in pulmonology, orthopedics, urology, diabetes &amp; endocrinology, gastroenterology, the Thyroid Cancer &amp; Parathyroid Institute, and the Children's Medical Center including the Jennifer Leigh Muma Neonatal Intensive Care Unit. In addition, we are the primary teaching hospital for the USF Health Morsani College of Medicine. Tampa General is committed to providing area residents with excellent and compassionate health care ranging from the simplest to the most complex medical services.</p> <p>Based on our review of the current Hospital Compare Rating System, we respectfully suggest CMS' consideration of the following recommendations.</p> | Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital | <a href="mailto:johnrothenberger@tgh.org">johnrothenberger@tgh.org</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>1. CMS should remove the publication of the Star Ratings until it appropriately resolves its methodology issues.</p> <p>All proposed changes should be fully vetted with key stakeholders to ensure patients have meaningful and accurate quality information. Anything less is not helpful for patient decision making and could, in fact, be detrimental to that decision-making process. Any proposed changes to the methodology should avoid disproportionately disadvantaging any category of hospitals. It is imperative that essential hospitals like Tampa General Hospital, 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</p> | Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital | <a href="mailto:johnrothenberger@tgh.org">johnrothenberger@tgh.org</a> | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>CMS should only include reliable and valid data and ensure grouping and group weights are balanced and reflect areas of importance for patients. Ratings should be driven by actual hospital performance rather than methodology. Methodology based use of loading factors drive performance within a measure group and give a false impression of quality performance within the group.</p>  | Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital | <a href="mailto:johnrothenberger@tgh.org">johnrothenberger@tgh.org</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>UnityPoint Health (“UPH”) appreciates this opportunity to provide comment on the public input request for “Overall Hospital Quality Star Rating on Hospital Compare.” UPH is one of the nation’s most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.</p> <p>In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.</p> <p>UPH appreciates the time and effort of CMS contractors, Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) and Lantana Consulting Group, Inc., in developing and proposing this feedback document and respectfully offers the following comments.</p> | <p>Jordan Russell, MPA, CPHQ, Director of Quality, Analytics &amp; Performance Excellence, UnityPoint Health</p> <p>Sabra Rosener, JD, VP, Government &amp; External Affairs, UnityPoint Health</p> | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a> | Health System         | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>UPH supports transparency and accountability by hospitals to consumers on measures that accurately and timely reflect the care environment, both in terms of quality and safety outcomes. While we appreciate that CMS paused public reporting of these Star Ratings to investigate significant changes to trend, we remain concerned that these ratings are not timely (i.e. based on old data), not intuitive (i.e. not aligned with patient priorities / ratings), not predictable (i.e. variances are subject to small, or even no, changes in performance) and, as currently structured, do not reflect true differentiated care related to patient experience and the quality and safety environment within a given hospital. As a provider organization, it is our hospital providers and staff that will ultimately field consumer questions and/or confusion about Star Ratings, and we will be responsible for explaining measure construction and trend deviations. Rating system confusion is further heightened as private organizations, such as The Leapfrog Group, now issue separate ratings using CMS datasets in part, and these ratings/scorecards are divergent from the Hospital Compare Star Ratings. As we reviewed this document, there is a recurring tension between transparency of meaningful measures versus detailed analytical precision. Star Ratings displayed in Hospital Compare are outward-facing, public ratings meant to encapsulate quality of care at Medicare-certified hospitals. According to the Hospital Compare website, ratings are intended to help consumers make decisions about where to get healthcare and to encourage hospitals to improve the quality of care that they provide. Before the analysis should shift to whether an Overall Hospital Quality Star Rating is based upon accurate and reliable indicators as detailed in this report, we believe the underlying question – whether this Star Ratings system is meaningful for consumers – must be answered.</p> | <p>Jordan Russell, MPA, CPHQ, Director of Quality, Analytics &amp; Performance Excellence, UnityPoint Health</p> <p>Sabra Rosener, JD, VP, Government &amp; External Affairs, UnityPoint Health</p> | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We do not believe that it is settled that consumers equate the Overall Hospital Quality Star Ratings as a meaningful measure when making healthcare decisions. And unlike other Star Ratings methodologies, we are not aware that hospital Star Ratings are directly connected to CMS initiatives. In comparison, Star Ratings for Medicare Advantage Plans impact bonuses, benefit offerings and marketing and enrollment flexibilities and Star Ratings for Nursing Homes trigger eligibility for participation in Medicare Accountable Care Organization value-based waiver arrangements. While Hospital Compare may seek to encourage hospitals to improve care, its alignment with current CMS quality programs is strained and does not provide clear priorities to hospitals.</p> <p>We would encourage CMS to refocus efforts on understanding what ratings/measures are meaningful for consumers and whether the current Star Ratings tool is appropriate prior to engaging in “very technical” modifications that “may not be easy for all stakeholders to interpret” to test ratings accuracy and precision. Although hospitals are subject to several CMS quality initiatives, the incorporation of some safety and quality measures are not necessarily prioritized by consumers. Our experience has been that consumers prioritize network coverage, service line presence, travel time and past care experience over quality ratings. The Patient &amp; Patient Advocate Work Group generally confirmed this with their interest in exploring a Hospital Compare filtering function that allows consumers to identify hospitals by location and healthcare network, rather than hospital characteristics. We find this preference particularly true for rural consumers in geographic areas with provider shortages and limited market competition.</p> | <p>Jordan Russell, MPA, CPHQ, Director of Quality, Analytics &amp; Performance Excellence, UnityPoint Health</p> <p>Sabra Rosener, JD, VP, Government &amp; External Affairs, UnityPoint Health</p> | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Aside from the Hospital Compare tool itself, critical to this discussion is CMS' marketing and outreach efforts to further engage consumers in shared decision-making related to healthcare. We applaud the creation and input from the Patient & Patient Advocate Work Group in this work and believe that this input should guide Hospital Compare development with the Provider Leadership Work Group and the Technical Expert Panel playing a supportive and operational role. In particular, the Patient & Patient Advocate Work Group awarded value to targeting meaningful information, intuitive and easily understood information, having the most current information, and avoiding potentially confusing or misleading information. As Hospital Compare continues to be developed, we would encourage CMS to expand consumer engagement efforts to market the Hospital Compare tool and its uses. | Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health<br>Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | As in integrated healthcare system, UPH participates in several CMS quality reporting and value-based initiatives. Over time, we have consistently commented on the need to streamline CMS quality reporting to focus on population health and the importance of consistent quality domains across settings of care for both providers and consumers. UPH also believes that domains should be weighted to accurately reflect high quality – process measures should be correlated to outcomes and outcome measures should receive higher weights.   | Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health<br>Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | I am writing on behalf of Richmond University Medical Center, located in Staten Island, New York. Richmond University Medical Center is a 300 plus bed healthcare facility and teaching institution serving borough residents as a leader in the areas of acute, medical and surgical care. We are the only dually-accredited Level I Adult Trauma Center and Level II Pediatric Trauma Center in the City of New York and Staten Island's only "baby friendly" designated hospital. Our Primary Service Area (PSA) includes 50 percent of Staten Island's total population, 73 percent of Staten Island's total minority population, 90 percent of the borough's African American population, 72 percent of Staten Island's total population living at or below federal poverty levels, 75 percent of Staten Island's public housing, all five of Staten Island's federally designated medically underserved areas, and the highest rates of mental illness and substance abuse disorder in the borough. Richmond University Medical Center has strong concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration. | Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center                          | <a href="mailto:ALutz@RUMCSI.org">ALutz@RUMCSI.org</a>                                     | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Inpatient Focus: For many community hospitals, the majority of our business and patient care is outpatient not inpatient. The measures and Star Ratings are really inpatient focused which does not truly reflect the care and service we provide.   | Wendy Blakemore MS, BSMT (ASCP), Director of Quality, Patient Safety and Utilization Management, Thompson Health | <a href="mailto:Wendy.Blakemore@thompsonhealth.org">Wendy.Blakemore@thompsonhealth.org</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | At Bassett Medical Center in Cooperstown, New York, we work diligently to provide a reliably safe journey for patients. Unfortunately, we believe the Star Rating does not represent the extent of our work or achieve the aim of increasing awareness of hospital quality and safety. As a result, we support CMS rethinking how it groups measures and defines measure groups, can better balance group scores, and decrease the frequency of refreshing ratings. We do not support user-defined, customized rating systems for several reasons.   | Ronette Wiley, Executive Vice President & Chief Operating Officer, Bassett Medical Center                        | <a href="mailto:jackelyn.fleury@bassett.org">jackelyn.fleury@bassett.org</a>               | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We are expressing and submitting some opinions and comments regarding possible updates and future considerations to the CMS Star Rating system.</p> <p>Vidant Health of Eastern North Carolina appreciates CMS’ opportunity to provide feedback regarding the Overall Hospital Quality Star Rating system. As a health system with eight hospitals and other physician practices, we provide care to over 29 counties. The majority of these counties are rural with unique socioeconomic status factors.</p> <p>We acknowledge that hospital ratings are vital to the autonomy of patients while making informed decisions regarding their healthcare.</p> <p>Our initial response and request is to suspend the current publication and future publications of the star rating system in Hospital Compare until the flaws of the rating system are adequately addressed (described below).</p> <p>Our first concern is that the rating system doesn’t provide adequate education of the overall rating system to the consumer. The rating system, by description “provides consumers with a simple overall rating generated by combining multiple dimensions of quality into a single summary score.” We’d argue that a single summary score for all hospitals can be dangerous for the consumer when making these critical, informed decisions. A single summary that provides a quick glance (similar to a Google or Amazon.com review) doesn’t reflect impactful socioeconomic factors of a community.</p> | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Again, we understand the value in providing consumers access to a summary to quality of care to assist in their healthcare decisions. However, until there is stability in reporting, adequate peer grouping, socioeconomic factors considered, and other issues addressed above, should be considered flawed in its approach.   | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The Rural Wisconsin Health Cooperative (RWHC) is pleased to offer our comments on the previously referenced Centers for Medicare &amp; Medicaid Services (CMS) Hospital Quality Star Rating on Hospital Compare Methodology Report (v3.0).</p> <p>Established in 1979, RWHC is owned and operated by forty-two rural acute, general medical-surgical hospitals. Our vision that rural Wisconsin communities become the healthiest in America has led us to a twin mission of advocacy and shared services.</p> <p>RWHC's overarching recommendation would be that CMS immediately suspend the star ratings for hospitals until updates to the calculation and reporting methods are done. We are disappointed that CMS chose to refresh the star ratings data after making very few of the proposed changes to the methodology suggested by stakeholders in the 2017 request for public input. RWHC further feels that the stale star ratings frozen on CMS' Hospital Compare website could have been removed from the website, acknowledging that revisions to the program were underway.</p> | Tim Size, Executive Director, Rural Wisconsin Health Cooperative | <a href="mailto:JLevin@rwhc.com">JLevin@rwhc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Thank you for your consideration of these comments on the Hospital Quality Star Rating on Hospital Compare Methodology Report (v3.0). The needs of rural patients are significant and we hope that our comments help lead to a greater understanding of some of the critical issues that face rural providers. We look forward to continuing our work together to mutual goals of improving access and quality of health care for all rural Americans.</p>   | Tim Size, Executive Director, Rural Wisconsin Health Cooperative | <a href="mailto:JLevin@rwhc.com">JLevin@rwhc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Doctors Hospital at Renaissance (OHR) thanks you for the opportunity to comment on CMS' Overall Hospital Quality Star Rating on Hospital Compare Public Input Request. OHR appreciates the chance to provide input on ways CMS can improve the methodologies for calculating hospital star ratings.</p> <p>OHR Health is a homegrown, grassroots physician-owned community health system developed by local physicians with the goal of addressing all of the health care needs of our community, while eliminating the need for our local residents to seek medical services outside the region. Located in the Rio Grande Valley1 of Deep South Texas, we serve an area of over 1.3 million people, and provide access to the highest -of-quality and award -winning health care in one of the poorest regions of the country.</p> <p>We are a world-class full-service health system with 500+ beds, offering the most comprehensive and best medical care in the Rio Grande Valley with over 70 specialties and sub-specialties, 700 physicians, 1,400+ nurses, a rehabilitation hospital, behavioral hospital, the only dedicated women's hospital south of San Antonio , a level III neo-natal intensive care unit that ranks among the top 5% in the world in terms of outcomes, a 24/ 7 level III trauma center, a robust clinical research division, and the flagship teaching hospital for the University of Texas Rio Grande Valley School of Medicine.</p> <p>OHR emphasizes the importance of publicly reporting performance of hospitals within the United Stat es. Hospital Compare provides valuable information to consumers, allowing patients the ability to make informed decisions regarding the hospital in which they choose to receive care.</p> | Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>CMS specifically requested input on proposals that update their methodologies for calculating Overall Hospital Quality Star Ratings. Specifically, OHR is providing comments on the following in CMS' Overall Hospital Quality Star Rating on Hospital Compare Public Input Request: Peer Grouping, Period to Period Shifts, and Alternative Clustering. DHR's comments are detailed below.</p> <p>1 The Rio Grande Valley is made up of the four Southern -most counties in Texas: Starr, Hidalgo, Cameron, and Willacy Counties.</p>   | Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health                                  | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Lehigh Valley Health Network (LVHN) welcomes this opportunity to comment on the Hospital Compare Star Ratings Public Comment on the refinement and maintenance of CMS' Overall Hospital Quality Star Ratings", which was prepared for the Centers for Medicare &amp; Medicaid Services (CMS or Agency) based on the feedback from Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) and Lantana Consulting Group, Inc. LVHN is a large academic health network consisting of five full service hospitals, a children's hospital, numerous community health centers, and pharmacy, imaging, laboratory, home-health and hospice services.</p> <p>The following are LVHN's key recommendations on methodologic improvements: Suspend the Star Ratings:</p> <p>LVHN continues to support transparency for health care consumers, however would like CMS to consider suspension of the Star Ratings from Hospital Compare until significant concerns related to the methodology are addressed. LVHN agrees that health care quality data should be readily available to the public and displayed to be easily understood. A rating that combines all of the multiple dimensional aspects into a summary score may not provide a patient or consumers with the information that is truly important for an individual's situation A single composite rating oversimplifies and misrepresents the complexity of caring for a large volume of diverse patients with multiple, complex comorbidities.</p> | Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a>       | Health system          | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | Overall Composite Ratings Add to Confusion:<br>A rating that combines all of the multiple dimensional aspects into a summary score may not provide a patient or consumers with the information that is truly important for an individual's situation. LVHN urges CMS to explore other approaches that directly compare patient groups, as a possible alternative model to use for rating hospitals. A single composite rating that combines disparate quality measures, particularly those that lack clinical nuance, oversimplifies the complex factors that must be taken in account when assessing the care quality. The hospital star ratings are not a useful metric of overall quality of a hospital but a metric of a few discreet processes of questionable representation of overall quality and most importantly outcomes. 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.   | Matthew McCambridge, M.D. MS, FACP, FCCP<br>SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a> | Health system         | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | On behalf of our over 460 member hospitals and health systems, the Texas Hospital Association ("THA"), appreciates the opportunity to provide comments on the above-referenced Public Input Request, published in February, 2019. THA and its members are committed to increasing access to appropriate health care and sharing hospital quality information to permit individuals to make informed decisions about their care. We appreciate your time and efforts in working through these issues. Since the rating system's inception, hospitals have raised concerns with the system and the potential for scores to inadequately and inaccurately reflect the care provided by the hospital. THA believes that the rating system should provide adequate transparency, continuity, and reliability to allow hospitals, patients, and providers equal opportunity to understand the measures and calculations behind a rating – which should translate to improve care outcomes for patients. Ultimately, we advocate for fairness among ratings, which would allow for hospitals that continuously provide high levels of care to be rated as doing such, and not suffer consequences based on unrelated and unknown metrics. | Cesar J. Lopez, Associate General Counsel; Texas Hospital Association  | <a href="mailto:clopez@tha.org">clopez@tha.org</a>                   | Hospital association  | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>The topics presented for public comment within the Public Input Request indicate that CMS understands the concerns with the rating system’s potential for instability and unreliability. We applaud the efforts to consider improving areas such as measure precision, peer grouping, and providing explicit approaches to calculating ratings. These efforts will assist in providing transparency, consistency, and a uniform understanding to the rating process.</p> <p>THA urges CMS to consider the comments submitted by the American Hospital Association, hospitals and systems located in Texas, and fellow hospital associations. Your attention to this is very much appreciated. We thank you for the opportunity to participate in the process, for your time and attention to this matter, and look forward to working with you. Please feel free to contact me at (512) 465-1027 or clopez@tha.org with any questions, comments, or if there is anything else THA can assist with.</p>  | Cesar J. Lopez, Associate General Counsel; Texas Hospital Association  | <a href="mailto:clopez@tha.org">clopez@tha.org</a>             | Hospital association   | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Michigan Medicine is pleased to have the opportunity to comment on the Hospital Compare Star Ratings. We agree that there is an essential need to understand how quality varies across hospitals, and fully appreciate the difficulty of creating composite quality rating. In a relative ranking system, there will always be concerns from those who do not perform well. We do not feel that this invalidates the attempt to measure quality, nor should it dissuade CMS from continuing to publish the ratings, even as methodological revisions are made.</p> <p>One factor that should be considered is the lack of alignment of the star ratings with other programs, such as VBP, HRRP, and HACRP. Many of the measures in these programs overlap with those in the star ratings, yet there is a lack of concordance in methodology across the programs. This could be easily addressed by tying incentives to performance in the various domains of the star ratings. MedPAC has made recommendations for revisions suggesting consolidation of the above programs and it would be beneficial to coordinate future approaches on ratings and incentives.</p> | Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan | <a href="mailto:svijan@med.umich.edu">svijan@med.umich.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | We are happy to engage in further discussions around improvement of the Hospital Compare star measures in the future. We have a strong health services research program that includes several faculty members who are noted experts in methods for comparing hospital performance. Please feel free to contact me if you have any questions   | Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan | <a href="mailto:svijan@med.umich.edu">svijan@med.umich.edu</a>                       | Medical University    | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>On behalf of the RWJ Barnabas Health Care System thank you for the opportunity to provide comments on the Overall Hospital Quality Star Ratings. Our system consists of 11 acute care hospitals. Our system has a wide range of hospitals that are impacted by the ratings, including Safety Net Hospitals, Academic and Teaching Hospitals, Tertiary services (only burn unit in NJ, only lung transplant program in NJ, trauma centers, 2 Heart transplant programs, regional NICU's to name just a few), one of the higher Medicare population hospitals in the country to general medical-surgical community based hospitals. We serve a wide range of populations in our 11 acute care hospitals.</p> <p>We strongly support one of the goals of star ratings – to make the data on Hospital Compare easier for consumers to use and understand. Patients, families and communities need information on the quality of hospitals to help them make important healthcare decisions.</p> <p>For these reasons we ask that CMS consider the comments and clear recommendations on the methodologies that American Hospital Association (AHA), New Jersey Hospital Association (NJHA) and the America's Essential Hospitals have submitted. We fully support the positions, recommendations and comments they have expressed.</p> | Deborah Larkin-Carney, RN, BSN, MBA, Vice President of Quality & Patient Safety; RWJBarnabas Health  | <a href="mailto:Deborah.larkin-carney@rwjbh.org">Deborah.larkin-carney@rwjbh.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | Upon review of the report released in February 2019 regarding updates to the CMS methodology for star ratings we offer the following comment. Thank you for accepting our feedback and we would be happy to serve as representative for CAH focus if needed.   | Melissa Obuhanick, RN, BS, CPPS, CPHQ, Director of Quality and Risk Management; Grand River Hospital District                  | <a href="mailto:mobuhanick@grhd.org">mobuhanick@grhd.org</a>               | Hospital               | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>The Ohio State University Wexner Medical Center (OSUWMC) appreciates the ongoing efforts of CMS to refine and improve its Hospital Compare methodology. Providing patients and their families with meaningful, understandable information on which to compare the different hospitals that they could choose for needed services is vital. This effort is especially challenging when trying to reduce the complex, multifaceted differences of hospital quality across hospitals serving different population groups and services into a single overall rating. Though we are a hospital system that comes out well under the current Hospital Compare data (we score a 4 and are working to improve further), we believe there remain critical limitations with the current methodology that warrant further remedy before Hospital Compare is truly an effective and fair tool for both patients and hospitals.</p> <p>OSUWMC includes the College of Medicine and its School of Health and Rehabilitation Sciences; the Office of Health Sciences, including the OSU Faculty Group Practice; various research centers, programs and institutes; The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute; and the Ohio State Health System, which includes University Hospital, East Hospital, Ohio State Harding Hospital, the Richard M. Ross Heart Hospital, Dodd Rehabilitation Hospital, the Ohio State Brain and Spine Hospital, the Ohio State Primary Care Network, CarePoint multispecialty outpatient facilities and Ohio State Walk-in Care Upper Arlington.</p> | Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center | <a href="mailto:Jennifer.carlson@osumc.edu">Jennifer.carlson@osumc.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>In fiscal year 2017, OSUWMC’s Ohio State Health System managed 61,701 patient admissions; 4,989 births; 1,763,707 outpatient visits; 131,439 Emergency Department visits; 16,921 inpatient surgeries; and 27,169 outpatient surgeries. OSUWMC has a transplant center, a psychiatric hospital, an FQHC look-alike clinic and is a new MSSP ACO participant. Our system includes two hospitals with distinct provider numbers, the Arthur G. James Cancer Hospital and the OSU Health System. In addition, as with all providers, we are impacted by emergency preparedness requirements.</p> <p>Our concerns fall into the following four broad categories:</p> <ul style="list-style-type: none"> <li>- Improvement in the efficacy of the individual quality measures</li> <li>- Reconsideration of using a single composite rating</li> <li>- Peer grouping</li> <li>- Timing of the sharing of Hospital Compare information</li> </ul> <p>The Star Rating approach creates a single composite rating for each hospital regardless of the different services provided within that hospital. The measures used to make up this rating cover a wide variety of procedures and conditions for different hospital settings (inpatient, outpatient and ED). Yet the final score only uses a small subset of the total data, regardless of number of measures that are relevant for different hospitals.</p> <p>This approach provides patient with no specific information on the exact service that they are pursuing. It can sow confusion and poor decision making for patient, especially in cases where a hospital’s ranking for the given procedure differs from its overall composite score.</p> <p>A better approach would be to provide a subset of measures than one composite score or in addition to the composite score. Such a subset would be more useful for patients making decisions and would help better direct quality improvement efforts at the hospital level.</p> | Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center | <a href="mailto:Jennifer.carlson@osumc.edu">Jennifer.carlson@osumc.edu</a> | Medical University    | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>It is always a delicate decision of when to begin to use a reporting system and when to keep reworking before its release. It is important not to let perfection be the enemy of the good. However, given the potential confusion and the severity of risk to the health and well being of patients with an inadequately designed measure, we believe that the Hospital Compare system is not ready for ongoing use.</p> <p>Given the need to address outstanding, significant concerns with the Star Ratings methodology, we recommend that CMS suspend use of the Star Rating.</p> <p>As mentioned initially, we appreciate the opportunity to provide comments on CMS's efforts to continue to refine and enhance the Quality Star Rating system. We, at OSUWMC, believe it is important that patients have the best information available for them to make informed health care decisions. The Quality Star Rating system can be such a vehicle, but there needs to be additional improvements and modifications for it to achieve its vision.</p> | Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center | <a href="mailto:Jennifer.carlson@osumc.edu">Jennifer.carlson@osumc.edu</a>               | Medical University    | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Thank you for the opportunity to provide comment on potential updates as well as broader concepts for enhancing the overall Hospital Quality Star Rating methodology.</p> <p>Established in 1872, Regions Hospital is a private, not-for-profit organization. The hospital provides health care services in St. Paul and its surrounding communities as well as for patients throughout Minnesota, western Wisconsin, and other Midwestern states. As a teaching hospital, Regions Hospital provides outstanding care in neuroscience, heart surgery, cardiology, oncology, emergency care, burn care, orthopedic care, mental illness and more. Regions is also one of the largest providers of charity care in Minnesota, providing nearly \$20 million in uncompensated services to care for 55,000 patients in 2017 alone. Finally, Regions is one of only three hospitals verified as a Level 1 Trauma Center for both adults and children in Minnesota.</p>  | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital                                     | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>We support CMS's ongoing progress towards increasing hospital quality and improving patient outcomes. However, we share concerns about the February 2019 release of CMS' Overall Star Rating raised by several organizations such as the American Hospital Association (AHA}, the American Association of Medical Colleges (AAMC}, and others. We request the removal of the CMS Star Ratings from the Hospital Compare website until CMS is able to address the multiple concerns with the methodology. It is imperative that the methodology be reviewed and accuracy be verified prior to public implementation. To this end, we recommend that CMS convene a stakeholder workgroup to provide an ongoing assessment of the program.</p> <p>Moreover, we suggest that CMS review a recently published study by Rush University which details many of the challenges associated performance measurement under the CMS Stars Rating program. They highlight problems arising from a) outlier patients with frequent readmissions, b) adjustment of readmission scores based on hospital volume, and star rating effect, c) socioeconomic status adjustment, and d) variability in ratings due to the Latent Variable Model. We concur with many of their findings.</p> <p>In general, we ask that CMS consider the following recommendations in order to improve the overall Star Rating methodology:</p> <p>Avoid a single composite rating that combines diverse quality measures, lacks clinical nuance, and is an oversimplification of complex factors. Patients likely choose a hospital for a condition or location and they need multifaceted information for informed health choices. One Overall Star Rating is not likely meaningful nor useful.</p> | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital              | Please refer to the Summary Report |



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| 3/29/19     | Overall Project & Methodology | <p>The use of a Latent Variable Model in the Star Ratings introduces variability and inconsistency, making changes in rating hard to interpret. A lack of consistency exists when compared to other CMS programs evaluating hospital safety: Value-based Purchasing (VBP}, Hospital Acquired Condition Reduction Program (HACRP}, and Overall Rating. Nearly the exact same measures are used across the programs yet there are inconsistent results on which hospital are safe or not safe. The Latent Variable Model has created confusion and contradicts the interpretation of a safe hospital. The intent of the CMS Overall Rating program was to provide clear information about hospital safety. Inconsistency of safety measurement creates confusion between results of various CMS programs. Patient and hospitals don't know what to believe is safe. The methodology needs to be re-evaluated to minimize this confusion.</p> <p>Thank you for the opportunity to provide comments on the potential updates to the Hospital Star Rating methodology. We share the agency's goal in ensuring a healthcare system oriented on high-value and cost efficient care. Please contact us if you have further questions or if we can provide additional details that would help in improving this methodology.</p> | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital  | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>Thank you for the opportunity to provide input on the CMS Quality Star Rating. Kaleida Health continues to support efforts to provide transparent data and information to our community so they can make informed health care decisions. As board member and chairman of the Kaleida Health Quality &amp; Patient Safety committee for the past 8 years, I have learned how important it is to deliver consistent, safe quality of care and service to the patients and families of our community. I have also come to appreciate the complexities of how quality is measured across various local, state and national programs, each with different definitions, methodologies and algorithms. The challenge we all face is to make this complex information useful to our patients and families, but unfortunately it is doing the opposite by adding confusion and leaving more questions than answers.</p>   | David A. Milling, MD, Chairman of Quality & Patient Safety Committee, Kaleida Health; Senior Associate Dean for Student and Academic Affairs, Associate Professor, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo | <a href="mailto:dmilling@buffalo.edu">dmilling@buffalo.edu</a>                           | Medical University    | Please refer to the Summary Report |



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| 3/29/19     | Overall Project & Methodology | <p>Since its inception in July 2016, the CMS quality star rating has been heavily disputed by hospitals and organizations across the country for inaccuracies and serious flaws in the methodology that ultimately lead to unfair ratings and comparisons. Despite CMS efforts to seek input and improve upon the methodology to address these issues, we are still in a current situation where the star ratings do not provide a fair and equitable comparison of quality and patient safety.</p> <p>Kaleida Health supports sharing meaningful information to our patients, however we believe that there is an unfair disadvantage in the rating methodology to high volume and large teaching hospitals that provide a broad spectrum of services. We urge CMS to consider the following points and recommendations:</p> <p>Remove the disproportionate weighting on certain variables/measures caused through the latent variable model, which essentially cancel out the performance of other measures within a domain.</p> <p>Transparency of data and logic prior to public release, and longer review period to sufficiently audit the results.</p> <p>Remove the quality star rating completely from Hospital Compare while CMS reviews and addresses the public input and recommendations. We cannot allow these ratings to exist until these flaws in the methodology are sufficiently addressed.</p> <p>On behalf of Kaleida Health and the Western New York community, we thank you for this opportunity to share our concerns as we support the need to improve the validity and quality of the star-rating system that CMS utilizes to rate the quality of care and service we provide to our patients and families.</p> | David A. Milling, MD, Chairman of Quality & Patient Safety Committee, Kaleida Health; Senior Associate Dean for Student and Academic Affairs, Associate Professor, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo | <a href="mailto:dmilling@buffalo.edu">dmilling@buffalo.edu</a> | Medical University    | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>Thank you for the opportunity to comment on the above-captioned request for public input on overall Hospital Quality Star Ratings. Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) supports the efforts of the Centers for Medicare &amp; Medicaid Services (CMS) to encourage transparency in care delivery across the entire health care industry and to provide consumers with information to make decisions about their care. We appreciate the agency soliciting feedback on how to improve the program.</p> <p>ZSFG is a safety net hospital owned and operated by the City &amp; County of San Francisco, which serves approximately 109,000 patients per year and provides over 20% of the city's inpatient care. ZSFG is the only level one Trauma Center in San Francisco serving many more bay area residents in need of trauma care.</p> <p>Additionally, ZSFG is one of the nation's top academic medical centers, partnering with the University of California, San Francisco School of Medicine on clinical training and research.</p> <p>ZSFG strives to provide quality healthcare with compassion and respect to patients that include our city's most vulnerable. We are dedicated to continuous improvement in what we do and how we work. ZSFG aims to provide a better patient experience, a healthier community and a more efficient healthcare system. We have found many components of the Hospital Star Rating System to be challenging, however, we will only discuss the few we see as requiring immediate attention.</p> <p>We ask CMS to reflect on public comment, not only from ZSFG but also from other stakeholders, such as America's Essential Hospitals and the American Hospital Association and consider how to best move forward with a meaningful Hospital Star Rating Program that fairly and accurately describes quality in hospitals. ZSFG strongly and respectfully requests CMS to refrain from publishing star ratings until it fully considers alternate proposals and reaches stakeholder consensus. We appreciate the opportunity to comment and thank CMS for its consideration.</p> | Troy Williams, RN, MSN, Chief Quality Officer; Zuckerberg San Francisco General Hospital and Trauma Center | <a href="mailto:leslie.safier@sfdph.org">leslie.safier@sfdph.org</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>Kaiser Permanente appreciates the opportunity to provide comments in response to the public input request on the Overall Hospital Quality Star Ratings on Hospital Compare. Below we provide feedback on each of the major sections of the white paper.</p> <p>Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.</p> <p>Kaiser Permanente appreciates the opportunity to provide feedback in response to the public input request. If you have questions or concerns, please contact Andy Amster at <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a> or (323) 259-4545.</p> | Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals | <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | Cedars-Sinai appreciates the opportunity to participate in this public comment period and we look forward to its outcome.  | Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center                | <a href="mailto:gail.grant@cshs.org">gail.grant@cshs.org</a>   | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>On behalf of The Mount Sinai Health System, we appreciate the opportunity to submit comments on the Overall Hospital Quality Star Rating on Hospital Compare. The Mount Sinai Health System is an integrated health system in New York committed to providing distinguished care, conducting transformative research, and advancing biomedical education. Structured around eight member hospital campuses and a single medical school, the Health System has an extensive ambulatory network and a range of inpatient and outpatient services—from community-based facilities to tertiary and quaternary care.</p> <p>We applaud CMS’s efforts to improve the Star Ratings and support many of the proposed changes. Generally, we believe the current model is statistically unreliable in its current form.</p> <p>We have communicated our opinions to CMS and the Yale group over the past months. More statistical rigor should be incorporated into the methodology to improve the confidence in the ratings and, where statistics fail the model, an explicit approach should be utilized.</p> <p>There are several key changes that we recommend:<br/>Please see below for more specific recommendations. We would welcome any opportunity to collaborate with CMS in order to determine an effective solution to modify and strengthen Star Rating methodology.</p> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a> | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Horizon Health would like to offer the following comments for the CMS Star Rating Discussion</p>  | <p>Amy Arnett, MS, RN,<br/>CPHQ, CPPS<br/>Quality/Infection Prevention Manager<br/>Horizon Health</p>   | <a href="mailto:aarnett@myhorizonhealth.org">aarnett@myhorizonhealth.org</a>     | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.<br>Star Ratings Removal: Lastly, I recommend removal of the star ratings from Hospital Compare until more meaningful methodology and program changes are completed and validated. The current methodology conflicts with data already available and publicly reported on Hospital Quality measures programs (VBP, HAC Reduction, HRRP). Under the two different methodologies, hospitals can score high on other quality measures, but still score poorly on the overall Star Rating. Variation in performance periods and extended performance periods does not illustrate current hospital performance. | Kathleen R. Reilly, B.S., RRT, CCMSCP<br>Director, Quality and Performance Improvement<br>Finger Lakes Health (Geneva General Hospital/Soldiers and Sailors Memorial Hospital) | <a href="mailto:Kathleen.Reilly@fhealth.org">Kathleen.Reilly@fhealth.org</a>     | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.<br>Thank you for considering my feedback.   | Diane C. Kantaros, M.D.<br>Corporate AVP of Clinical Quality Health Quest  | <a href="mailto:dkantaros@Healthquest.org">dkantaros@Healthquest.org</a>         | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | We thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the methodology under re-evaluation for the Overall Hospital Quality Star Rating. Press Ganey is the leading provider of patient experience measurement, performance analytics and strategic advisory solutions for health care organizations across the continuum of care. For more than 30 years, our mission has been to help health care organizations reduce patient suffering and improve clinical quality, safety and the patient experience. As of January 1, 2019, we served more than 41,000 health care facilities, including partnering with over 75% of all acute care hospitals.   | Kaycee M. Glavich<br>Director of Policy, Press Ganey   | <a href="mailto:kaycee.glavich@pressganey.com">kaycee.glavich@pressganey.com</a> | Individual             | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We support CMS’ effort to provide additional transparency on hospital quality. Health care consumers are increasingly seeking valid performance data to inform their decision-making and ultimately increase the value of the care they receive. In particular, we believe it is important that patients have access to information that is accurate, reliable and consistent across all units being measured—in this case, hospitals. Star ratings are a patient-friendly means of communicating some of that information. However, we continue to be concerned with the usefulness of the Overall Hospital Quality Star Rating, because most hospitals receive a three-star ranking, appearing as simply “average”. A rating system that incorporates several varying measures of quality and yet results in very little differentiation has limited utility both for patient decision-making and for providing incentives for hospital performance improvement. Additionally, we support a rating system and calculation that is easier for the consumer and hospital to understand. Within the Hospital Compare tool, CMS could provide more meaningful differentiation among hospital quality by allowing individuals to view the numeric value associated with each hospital’s Overall Hospital Quality Star Rating.</p> <p>Press Ganey would like to thank CMS for this opportunity to provide input on the proposed changes to the Overall Hospital Quality Star Ratings. For further information on our comments and recommendations, please contact: Kaycee M. Glavich, Director of Policy; 404 Columbia Place, South Bend, IN 4660; (574) 401-8647; <a href="mailto:kaycee.glavich@pressganey.com">kaycee.glavich@pressganey.com</a></p> | Kaycee M. Glavich<br>Director of Policy,<br>Press Ganey                                     | <a href="mailto:kaycee.glavich@pressganey.com">kaycee.glavich@pressganey.com</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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 &amp; 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 <a href="http://CalQualityCare.org">CalQualityCare.org</a>).</p>   | Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association | <a href="mailto:nhoffman@calhospital.org">nhoffman@calhospital.org</a>           | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association | <a href="mailto:nhoffman@calhospital.org">nhoffman@calhospital.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | 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. | Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association | <a href="mailto:nhoffman@calhospital.org">nhoffman@calhospital.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Thank you for the opportunity to share our comments regarding the Hospital Quality Star Ratings methodology. As part of the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic is dedicated to finding answers for patients through medical care, research and education. With more than 3,600 physicians and 60,000 employees, Mayo Clinic brings together teams of specialists with a relentless and unwavering commitment to excellence. This has spawned a rich history of solving the most serious and complex medical challenges – one patient at a time. Each year, more than 1,000,000 people from all 50 states and 140 countries come to Mayo Clinic to receive the highest quality care at sites in Minnesota, Arizona and Florida. In addition, Mayo Clinic Health System, a family of clinics, hospitals and health care facilities, serves communities in Iowa, Minnesota and Wisconsin.                   | John D. Poe, Chair, Quality and Affordability, Mayo Clinic                                  | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a> | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>At Mayo Clinic, our core value is that the needs of the patient come first. We believe that patients deserve clear, understandable and meaningful quality information to aid them in making their health care decisions. As a provider, we also believe that quality information should be based on a transparent methodology that allows providers to identify areas for improvement. In summary, it is our general belief that the current approach, though intended to aid consumers' choice in hospitals, falls short of its potential utility because it does not facilitate an understanding of which measures hospitals must improve in order to provide high-quality patient care.</p> <p>Below you will find our specific and general responses to this Public Input Request, and again we thank CMS for this opportunity.</p>   | John D. Poe, Chair, Quality and Affordability, Mayo Clinic | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Over the past three years, much has been discussed regarding latent variable modeling, selection and weighting of measures, clustering and other aspects of the Hospital Quality Star Ratings methodology that may lead to an unreliable estimation of hospital quality and thus could benefit from revision. With methodological revisions, we believe that the Hospital Quality Star Ratings have great potential to more accurately aid consumers' choice as well as provide hospitals with meaningful quality metrics that promote continual improvement in patient care.</p> <p>Mayo Clinic is honored to care for more than one million people a year including more than 500,000 Medicare and Medicaid patients. We have long served as a strong voice for our patients in improving American's health care system. We applaud your efforts to improve the Hospital Quality Star Rating methodology and encourage you to continue to focus on providing health consumers with clear, understandable and meaningful quality information that also aids health providers in improving America's health care delivery system.</p> | John D. Poe, Chair, Quality and Affordability, Mayo Clinic | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Thank you for the opportunity to comment on the on overall hospital quality star ratings. Maricopa Integrated Health System (MIHS) supports the efforts of the Centers for Medicare &amp; Medicaid Services (CMS) to encourage transparency and to provide consumers with information to make care decisions. We have concerns with the underlying methodology and overall usefulness of the ratings. We appreciate the opportunity to provide feedback on how to improve the program and CMS' willingness to act when it is clear there are opportunities with the ratings. Through our integrated health system, we offer a continuum of care through our acute care hospital care, including but not limited to burn and trauma services, outpatient primary care in 13 ambulatory centers, with a Comprehensive Center with over 20 specialties, mental health services in the acute environment, as well as, outpatient centers, and wraparound services critical to disadvantaged patients. The system provides most of the care for high acuity burns; as well as, court ordered mental health services for Maricopa County.</p> <p>MIHS supports sharing meaningful hospital quality information with patients. However, we believe there is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most vulnerable patients. We urge CMS to cease publication of the ratings and consider the following comments before moving forward to avoid confusion among patients, as well as any disproportionate effect on essential hospitals.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>Hospitals were the first providers to voluntarily supply quality data for the public and have been doing so for more than a decade. We are committed to transparency and accuracy in quality measurement. We understand the importance of quality improvement reporting, especially with increasing demands for accountability, movement toward value-based purchasing, and growing consumer engagement. We continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. We know the importance of sound data to reduce disparities in care, and we lead efforts to close gaps in quality for racial and ethnic minorities. By involving patients as active participants in their care, we 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 inherently a complex and personalized decision—the choice of where to seek care. Further, a hospital’s single, simplified rating might fail to capture its particular expertise in an area of care most important to a given patient population. 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.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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. Unfortunately, these do not enable 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.</p>   | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>a. CMS should seek impartial review of the star ratings methodology and broad stakeholder input.</p> <p>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.</p> <p>b. CMS should not publish star ratings until the agency appropriately resolves issues with the methodology.</p> <p>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.</p> <p>We stand ready to work with CMS and others on better ways to empower patients and their families with information about health care quality.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The Joint Commission appreciates the opportunity to comment on the Centers for Medicare &amp; Medicaid Services (CMS), Department of Health and Human Services (HHS), Overall Hospital Quality Star Rating on Hospital Compare Public Input Request.</p> <p>Founded in 1951, The Joint Commission seeks to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. An independent, not-for-profit organization, The Joint Commission accredits and/or certifies more than 22,000 health care organizations and programs in the United States. The Joint Commission evaluates health care organizations across the continuum of care, including most of the nation's hospitals. In addition, Joint Commission programs encompass clinical laboratories, ambulatory care and office-based surgery facilities, behavioral health care, home care, hospice, and long-term care organizations. Joint Commission accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting state-of-the-art performance standards. Although accreditation is voluntary, a variety of federal and state government regulatory bodies, including CMS, recognize and rely upon The Joint Commission's decisions and findings for Medicare or licensure purposes.</p> <p>The Joint Commission has been a nationally recognized leader in performance measurement for over 30 years. As such, The Joint Commission has gained extensive experience and expertise in the identification, development, specification, testing, and implementation of standardized performance measures. From this experience, The Joint Commission believes that revisions to the methodology used in the Overall Hospital Quality Star Rating must (1) be based on the most current data, (2) include measures of precision, (3) make clear to hospitals why they received their star rating, and (4) provide insight for providers who seek to improve their ratings in the future.</p> | Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission | <a href="mailto:PRoss@jointcommission.org">PRoss@jointcommission.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Broadly, we urge extreme care when using outcome measures for accountability. Differences in patient populations across providers require careful risk adjustment of outcome measures to document valid differences in care between providers. CMS must approach this task as rigorously as has been done for process measures if they are to successfully identify and reward providers who achieve the best outcomes. <sup>1</sup> As a general comment, the process measures grouping, which contains the most accurate data, should receive more weight in calculating the Overall Hospital Star Rating. Process measures also point facilities towards concrete steps for quality improvement. The Joint Commission believes that the weight for process measures grouping should better reflect the quality of the data and the opportunities for improvement  | Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission | <a href="mailto:PRoss@jointcommission.org">PRoss@jointcommission.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>The Kansas Hospital Association (KHA) welcomes the opportunity to provide comments on CMS' proposed changes to the Star Ratings methodology. KHA is a voluntary, non-profit organization that provides leadership and services to 124 member Kansas hospitals and other affiliated healthcare organizations to achieve our shared vision of optimal health for all Kansans. Importantly, KHA supports making meaningful, accurate quality data available in an easy to understand format for patients and the public.</p> <p>While KHA appreciates CMS' effort to reevaluate the STAR ratings, we were disappointed that CMS published Star Ratings updates for hospitals at the end of February at the same time that it sought public input on proposed changes to address problems with the current methodology. It was our hope that CMS address the methodology changes first rather than publish ratings based on flawed methodology.</p> <p>Based on our review of the Star Ratings methodology, proposed changes and input from member hospitals, KHA offers several comments regarding the proposed changes.</p> | Karen Braman, Senior Vice President, Healthcare Strategy and Policy Kansas Hospital Association                     | <a href="mailto:kbraman@kha-net.org">kbraman@kha-net.org</a>             | Hospital Association                            | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Single overall rating - While we applaud CMS' efforts to enhance the validity of the Star Ratings and we strongly support the goal of making data on Hospital Compare easier to understand, KHA believes that one overall rating for each hospital may not provide patients with meaningful information regarding specific care that they need. A single rating may not capture information regarding an area of expertise that most important to a patient. Further, KHA agrees with the American Hospital Association's recommendation to CMS to explore developing an alternative approach to star ratings based on specific clinical conditions or topic areas.  | Karen Braman, Senior Vice President, Healthcare Strategy and Policy<br>Kansas Hospital Association | <a href="mailto:kbraman@kha-net.org">kbraman@kha-net.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | On behalf of the New Jersey Hospital Association (NJHA) and its over 400 hospital, health system, PACE and post-acute members, thank you for the opportunity to provide comments on the Overall Hospital Quality Star Ratings. NJHA appreciates that CMS and its partners, CORE and Lantana, are soliciting input from stakeholders on these important ratings. Concerns around the methodology and overall ratings are widespread in the provider community, which fears these shortcomings confuse rather than assist healthcare consumers as they seek to learn more about healthcare quality. The decision to delay publishing the July 2018 update and reevaluate certain aspects of the methodology was prudent and welcomed by our members. While the February 2019 update was not postponed to address similar issues, the opportunity to comment is very much appreciated.<br><br>Patients, families and communities deserve clear and meaningful quality information to help them make important healthcare decisions. That is why we have long supported transparency on quality. NJHA has taken the lead in educating New Jersey healthcare consumers. Our NJ Care Compare website, first established in 2007, is a service to empower patients looking for healthcare quality data and help them navigate the complex web of report cards and quality data. | Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association                 | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a>       | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We believe educating patients about healthcare quality is a critical part of our collective efforts to make healthcare safer and more efficient.</p> <p>We continue to strongly support one of the foundational goals of star ratings – to make the data on Hospital Compare easier for consumers to use and understand. However, we remain concerned that this laudable goal is supported by a star ratings approach that does not provide an accurate picture of hospital quality performance. Since CMS began work on overall star ratings in 2015, healthcare organizations have repeatedly shared concerns about the star ratings methodology.</p> <p>NJHA urges CMS to remove the existing star ratings from Hospital Compare while its important work of improving the methodology continues. We appreciate the desire for the ratings to reflect the most current quality data. Yet CMS’s public comment underscores the many problems with the current methodology. Unless and until the ratings methodology is improved, it will be difficult for hospitals and the public to have confidence that star ratings portray hospital performance accurately.</p> <p>The roughly one dozen potential changes to the star ratings methodology outlined in the request for comment attempt to address several important issues with star ratings and merit serious consideration. However, NJHA asserts that only three of the proposals should be pursued further at this time – empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and using an “explicit” scoring approach. The remaining proposals either fail to address important shortcomings with star ratings, or we simply do not have enough information to judge their impact.</p> | Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>NJHA also urges CMS to consider other steps to improve star ratings that are not addressed in the draft report. We believe it is important that these steps be taken prior to considering implementation of any other changes to the star ratings. Specifically, CMS should: engage experts on latent variable models (LVM) to ensure its calculation approach is executed correctly; examine how to mitigate the impact of outliers in calculating readmissions measures in the ratings; develop an alternative approach to star ratings in which, instead of an overall rating, hospitals receive ratings on specific clinical conditions or topic areas.</p>   | Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a> | Hospital Association   | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>Yet, as noted above, 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 because it is nearly impossible for hospitals to predict how well they may perform on star ratings and the extent to which performance on any single measure drives their overall ratings.</p> <p>CMS has indicated in the past that it views the star ratings system as a tool for patients that was not intended to be used by hospitals to support quality improvement efforts. But the reality is that any data that are reported publicly can and do drive hospitals to seek to improve their performance or maintain a high level of performance. A star ratings approach with less uncertainty could help hospitals better benchmark their performance against others. Furthermore, hospitals are reporting that private sector payers are increasingly expressing interest in using star ratings for contracting purposes.</p>   | Jonathan Chebra,<br>Senior Director,<br>Federal Affairs, New<br>Jersey Hospital<br>Association | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>For these reasons, and most importantly in the best interests of healthcare consumers, the continued use of a star ratings approach that is inherently unpredictable and not tied to hospital quality improvement efforts may no longer be tenable. We encourage CMS to continue exploring a more explicit approach to star ratings. We acknowledge that a more explicit system would involve some choices about what measures to include, how to weight particular measures and what performance targets to set. CMS could consider adopting some more empirically based approaches to assist in this work. For example, to identify the weights for particular groups of measures, CMS could undertake systematic surveying of patients to identify the aspects of quality that would be of the greatest importance to them. In addition, the criteria proposed in the public comment document for creating and maintaining measure groups could be adapted for use in a more explicit approach to star ratings. Again, we thank CMS and its partners for the opportunity to comment on the Overall Hospital Quality Star Ratings and appreciate the work that is being done.</p> | Jonathan Chebra,<br>Senior Director,<br>Federal Affairs, New<br>Jersey Hospital<br>Association | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The Massachusetts Health &amp; Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates this opportunity to comment on proposed changes to the Centers for Medicare &amp; Medicaid Services (CMS) hospital overall star ratings system.</p> <p>As longstanding supporters of transparency, Massachusetts hospitals believe that patients, families, and communities should have valid, clear, and meaningful quality information to help them make important healthcare decisions. MHA strongly supports the comments the American Hospital Association (AHA) and other stakeholders have issued urging CMS to address the substantial flaws in the star ratings methodology that have existed since the ratings inception in 2016. We continue to be concerned that one of CMS's laudable goals with star ratings – to give a meaningful, simplified view of hospital quality to consumers – is being compromised by a methodology that can lead to inaccurate, misleading comparisons of quality performance.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>MHA appreciates CMS’s ongoing efforts to solicit stakeholder feedback on how to improve the ratings approach. The roughly one-dozen potential changes to the star ratings methodology outlined in the request for comment attempt to address several important issues with star ratings and merit serious consideration. However, MHA believes that only three of the proposals should be pursued further at this time: empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and using an “explicit” scoring approach. The remaining proposals either fail to address important shortcomings with star ratings, or simply do not have enough information for us to judge their impact.</p> <p>MHA also urges CMS to consider other steps to improve star ratings that are not addressed in the draft report. We believe it is important that these steps be taken prior to considering implementation of any other changes to the star ratings. Specifically, CMS should:</p> <ul style="list-style-type: none"> <li>• Engage a small group of experts on latent variable modeling (LVM) to ensure its calculation approach is executed correctly; better yet, eliminate the use of this model altogether and engage a group of experts on a better modeling system.</li> </ul> <p>Develop an alternative approach to star ratings in which, instead of an overall rating, hospitals receive ratings on specific clinical conditions or topic areas.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Accuracy. The ratings should be based on rigorous quality measures and employ appropriate and correctly executed statistical approaches to combining performance across measures. Users and hospitals should expect that differences in star ratings across hospitals are substantiated by clinically and statistically meaningful differences in underlying performance.</p> <p>As currently designed, star ratings continue to include measures with known methodological flaws (e.g., the patient safety indicator (PSI) composite measure, which lacks validity). And concerns have been raised in the past about whether independent experts can assess whether the LVM calculation was being executed correctly. Though CMS is to be commended for trying to promote transparency and consumer engagement for quality of care at hospitals, the effort is blunted or worse, harmful, if consumers are forming incorrect conclusions about hospital quality due to a flawed system of measurement.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Additional Considerations</p> <p>MHA believes that while not included in the public comment proposal, CMS's ongoing work to improve hospital star ratings is also worth attention. Validation of computational approach. MHA urges CMS to engage a group of experts on LVM to ensure its calculation approach is executed correctly or to explore a better, alternative approach to modeling a composite rating (and suspending star ratings until such a model is completed and validated). We greatly appreciated CMS's 2017 decision to suspend star ratings briefly and to make some changes to how it was executing the existing methodology after discovering issues that led to the misclassification of hospitals. Unfortunately, we believe there still may be some problems leading to misclassification. This includes the need to correct the individual measure loading factors, but not by using confidence interval weightings as discussed above.</p>                                       | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Topic-specific star ratings. MHA urges CMS to consider developing an alternative approach to star ratings in which, instead of an overall rating, hospitals receive ratings on specific clinical conditions or topic areas. As we have noted in this letter, we believe there are ways in which CMS can improve its approach to creating a single overall star rating for hospital quality. At the same time, we continue to have significant concerns about the conceptual underpinnings of star ratings. The measures included in the ratings were never intended to create a single, representative score of hospital quality. Furthermore, the ratings often do not reflect the aspects of care most relevant to a particular patient's needs. That is why MHA has encouraged CMS to consider developing an alternative approach in which star ratings are done by topic area, such as patient safety, patient experience of care, and cardiac care. This approach may lessen the possibility of consumers receiving misleading information about quality. | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Eliminate the star ratings altogether. MHA urges CMS to consider eliminating the star ratings permanently and instead continue to highlight hospital performance on individual categories related to quality of care. The very notion of trying to quantify overall hospital quality into a single composite score is flawed in its design of simplifying very complex data into a "one size fits all" rating that may not be truly representative of all cases. The data and performance rates for the inpatient and outpatient quality reporting measures should speak for themselves as individual measures.  | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The University of Chicago Medical Center (UCMC) appreciates the opportunity to comment on the pub) input request to provide feedback on potential updates and future consideration for the methodology of the Overall Hospital Quality Star Rating on Hospital Compare, issued by the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>UCMC has been a leading provider of medical care on the South Side of Chicago since 1927. We offer leading edge medical care in all specialty fields. For many years, UCMC has been among the top Medicaid providers in Illinois. The most recent state data indicates that UCMC is the # 1 provider in the state in Medicaid inpatient days and outpatient services. Approximately 65% of our patient days are Medicaid and Medicare. We opened an adult level one trauma center in 2018. It quickly became one of the busiest trauma centers in the state, with an extremely high rate of penetrating trauma. Our violence recovery program is designed to help trauma victims change their life circumstances with appropriate social services interventions.</p> <p>UCMC adopts the comments submitted in this matter by the Association of American Medical Colleges. We would respectfully request that particular attention be focused on the following points</p> | <p>Kenneth S. Polonsky, MD, Richard T. Crane Distinguished Service Professor, Dean of the Division of Biological Sciences and Pritzker School of Medicine, Executive VP for Medical Affairs</p> <p>Stephen Weber, MD, Professor of Medicine, Chief Medical Officer, VP Clinical Effectiveness, VP Governmental Affairs, University of Chicago Medicine</p> <p>Ben Gibson, VP for Governmental Affairs</p> | <a href="mailto:benjamin.gibson@uchospitals.edu">benjamin.gibson@uchospitals.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>An Overall Hospital Compare Composite Rating Adds to Confusion About Hospital Quality</p> <p>UCMC strongly supports making quality data available in an easy to understand format for patients, payers, employers and the general public. While we support efforts for greater transparency, we believe that this information must be displayed in a fair and meaningful fashion. A single composite rating that combines diverse quality measures, particularly those that lack the necessary rigor and clinical nuance, oversimplifies the complex factors that must be taken in account when assessing the overall quality and safety of care provided by an institution. 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.</p> <p>Rather than using a single composite score methodology, UCMC recommends the development of ratings for subsets of measures, which should ultimately be more meaningful and actionable for both patients and consumers, but also for the hospital's quality improvement efforts. The measures on Hospital Compare cover a wide variety of conditions and procedures for the inpatient, outpatient, and emergency department settings, yet under the current methodology only a handful of scores ultimately determine a hospital's overall quality rating. In addition, the currently methodology compares hospitals regardless of the number of measures for which the hospital is scored or services the hospital offers. A rating that combines all of these multiple dimensions into a summary score may not provide a patient or consumers with the information that is truly important for an individual's situation. Even worse, the current system does not shine light on the differences between hospitals compared or disclose the areas where a given hospital might not provide a given service or may lack a measure score. Patients may choose a hospital for a particular condition or location at one time, and may make a different choice at another time and should have better access to quality information to inform those choices. We are concerned that patients lack the multifaceted information they need to aid them in their healthcare choices. Distilling a large amount of information into one overall rating may not be useful and is harmful. We would be pleased to meet with you to discuss our concerns if that would be helpful.</p> | <p>Kenneth S. Polonsky, MD, Richard T. Crane Distinguished Service Professor, Dean of the Division of Biological Sciences and Pritzker School of Medicine, Executive VP for Medical Affairs</p> <p>Stephen Weber, MD, Professor of Medicine, Chief Medical Officer, VP Clinical Effectiveness, VP Governmental Affairs, University of Chicago Medicine</p> <p>Ben Gibson, VP for Governmental Affairs</p> | <a href="mailto:benjamin.gibson@uchospitals.edu">benjamin.gibson@uchospitals.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Koenig, Lane et al. <i>Complication Rates, Hospital Size, and Bias in the CMS Hospital-Acquired Condition Reduction program</i>. <u>American Journal of Medical Quality</u>. December 19, 2016. Retrieved from: <a href="https://journals.sagepub.com/doi/abs/10.1177/1062860616681840">https://journals.sagepub.com/doi/abs/10.1177/1062860616681840</a>.</p> <p>Blay Jr., Eddie et al. <i>Evaluating the Impact of Venous Thromboembolism Outcome Measure on the PSI 90 Composite Quality Metric</i>. <u>The Joint Commission Journal on Quality and Patient Safety</u>. March 2019. Retrieved from: <a href="https://www.jointcommissionjournal.com/article/S1553-7250(18)30220-4/pdf">https://www.jointcommissionjournal.com/article/S1553-7250(18)30220-4/pdf</a></p> <p>“Med PAC Comments on FY 2014 IPPS Proposed Rule.” June 25, 2013. Retrieved from: <a href="http://www.medpac.gov/documents/comments-letters/medpac’s-comments-on-cms’s-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0">http://www.medpac.gov/documents/comments-letters/medpac’s-comments-on-cms’s-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0</a></p> <p>Rajaram, Ravi et al. <i>Concerns About Using the Patient Safety Indicator 90 Composite in Pay-For-Performance Programs</i>. <u>JAMA</u>. Vol 313, No. 9. March 3, 2015. Retrieved from: <a href="http://jama.jamanetwork.com/article.aspx?articleid=2109967">http://jama.jamanetwork.com/article.aspx?articleid=2109967</a></p> <p><i>Medicare’s Hospital Acquired Condition Reduction Program</i>. <u>Health Affairs: Health Policy Briefs</u>. August 6, 2015. Retrieved from: <a href="http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142">http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142</a></p> | <p>Kenneth S. Polonsky, MD, Richard T. Crane Distinguished Service Professor, Dean of the Division of Biological Sciences and Pritzker School of Medicine, Executive VP for Medical Affairs</p> <p>Stephen Weber, MD, Professor of Medicine, Chief Medical Officer, VP Clinical Effectiveness, VP Governmental Affairs, University of Chicago Medicine</p> <p>Ben Gibson, VP for Governmental Affairs</p> | <a href="mailto:benjamin.gibson@uchospitals.edu">benjamin.gibson@uchospitals.edu</a> | Medical University     | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>Ascension appreciates the opportunity to review and submit our responses to several Overall Hospital Quality Star Rating methodology updates proposed by the Centers for Medicare &amp; Medicaid Services (CMS) for both immediate implementation and future consideration.</p> <p>Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2018, Ascension provided nearly \$2 billion in care of persons living in poverty and other community benefit programs. Ascension includes approximately 156,000 associates and 34,000 aligned providers. The national health system operates more than 2,600 sites of care – including 151 hospitals and more than 50 senior living facilities – in 21 states and the District of Columbia, while providing a variety of services including physician practice management, venture capital investing, investment management, biomedical engineering, facilities management, clinical care management, information services, risk management, and contracting through Ascension’s own group purchasing organization.</p> <p>We appreciate CMS’s ongoing receptiveness to feedback on the Overall Hospital Quality Star Rating methodology and the ongoing engagement between CMS, industry stakeholders, and subject matter experts. As part of our input in response to CMS’s proposals, we strongly echo the recommendation made by the American Hospital Association (AHA) that CMS engage a group of experts on latent variable models (LVM) to ensure its calculation approach is executed correctly if the LVM is to remain in place. Continued and inclusive conversations around the accuracy and utility of the Star Ratings methodology will serve to promote ongoing improvements and ensure patients are able to best use the Hospital Compare tool in the ways originally intended. In response to the request for public input at hand, however, we offer the following feedback and recommendations. We appreciate your consideration of these comments and stand ready to serve as a partner and resource on this issue going forward.</p> | Peter M. Leibold,<br>Chief Advocacy<br>Officer, Ascension | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Proposed Future Considerations for the Overall Hospital Quality Star Rating Methodology</p> <p>Explicit Approach to Calculating Overall Hospital Quality Star Ratings</p> <p>CMS requests feedback on the advantages and disadvantages of an explicit approach to calculating Overall Hospital Quality Star Ratings and on how best to implement and maintain such an approach. We would support CMS considering other methodologies for determining the Overall Hospital Quality Star Ratings. A direct arithmetic calculation of ratings, like that used in the context of several other CMS Quality Programs (e.g., the Hospital Value-Based Purchasing Program (VBP), the Hospital Readmissions Reduction Program (HRRP), and the Hospital-Acquired Condition Reduction Program (HAC)), would produce star ratings that can be more easily understood. We also recommend that, whatever approach is used for the 5-star ratings methodology, the results more closely align with the performance characteristics of the other CMS Quality Programs (e.g., VBP, HRRP, and HAC). Having the results of all such programs aligned and providing the same perspective on a hospital's quality will greatly improve the general acceptance and utility of these ratings programs. We appreciate your consideration of this input. We applaud CMS's ongoing commitment to improving the accuracy of the Overall Hospital Star Ratings and look forward to serving as a resource as you continue this important work.</p> | Peter M. Leibold,<br>Chief Advocacy<br>Officer, Ascension        | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | We note in the 48 pages of "Overall Hospital Quality Star Rating on Hospital Compare Public Input Report" neither physician nor clinician nor hospitalist is mentioned, not even once.  | Dale N. Schumacher,<br>MD, MPH, President,<br>Rockburn Institute | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>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 &amp; 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.</p> <p>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 essential hospitals’ patients are uninsured or covered by Medicaid or Medicare. More than 50 percent of patients discharged from essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that essential hospitals are best able to provide.<sup>1</sup></p> <p>Through their integrated health systems, essential hospitals offer the continuum of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse treatment, and wraparound services critical to disadvantaged patients. Many of the specialized inpatient and emergency services they provide are not available elsewhere in their communities.</p> | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Essential hospitals are continually called on to meet the complex clinical and social needs of the patients that 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 offered by 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.</p> <p>America’s Essential Hospitals supports sharing meaningful hospital quality information with patients. However, we believe there is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most vulnerable patients. We urge CMS to cease publication of the ratings and consider the following comments before moving forward to avoid confusion among patients, as well as any disproportionate effect on essential hospitals.</p> <p><sup>1</sup>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.</p> | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>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.</p> <p>America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. 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.</p> <p>However, a single rating for a hospital oversimplifies what is inherently a complex and personalized decision—the choice of where to seek care. Further, a hospital’s single, 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.</p> | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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. Unfortunately, these do not enable 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</p>  | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | 2. CMS should only include reliable and valid measures in the calculation of star ratings, and ensure measure grouping and group weights are balanced and reflect areas of importance for patients.  | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>4. CMS should re-examine the underlying methodology of the star ratings to improve their reliability, predictability, and accuracy.</p> <p>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.</p> <p>As seen between the December 2017 release and previously planned July 2018 released, 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.”</p> | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | 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 critical, universal quality measures, such as the infection measures, might have almost no importance in determining 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 while not emphasizing 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. | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>b. CMS should seek impartial review of the star ratings methodology and broad stakeholder input.</p> <p>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.</p> <p>c. CMS should not publish star ratings until the agency appropriately resolves issues with the methodology.</p>   | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>We stand ready to work with CMS and others on better ways to empower patients and their families with information about health care quality.</p>   | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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 &amp; 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.</p> <p>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 essential hospitals' patients are uninsured or covered by Medicaid or Medicare. More than 50 percent of patients discharged from essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that essential hospitals are best able to provide.<sup>1</sup></p> | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System  | <a href="mailto:maria.iliescu@sinai.org">maria.iliescu@sinai.org</a>               | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>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.</p> <p>America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. 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.</p> <p>However, a single rating for a hospital oversimplifies what is inherently a complex and personalized decision—the choice of where to seek care. Further, a hospital’s single, 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.</p> | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System | <a href="mailto:maria.iliescu@sinai.org">maria.iliescu@sinai.org</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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. Unfortunately, these do not enable 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</p>  | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System | <a href="mailto:maria.iliescu@sinai.org">maria.iliescu@sinai.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>4. CMS should re-examine the underlying methodology of the star ratings to improve their reliability, predictability, and accuracy.</p> <p>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.</p> <p>As seen between the December 2017 release and previously planned July 2018 released, 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.”</p> | Mira Iliescu-Levin,<br>SHS VP/CMO of<br>Acute Hospitals, Sinai<br>Health System | <a href="mailto:maria.iliescu@sina i.org">maria.iliescu@sina i.org</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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 critical, universal quality measures, such as the infection measures, might have almost no importance in determining 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 while not emphasizing 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.</p>   | Mira Iliescu-Levin,<br>SHS VP/CMO of<br>Acute Hospitals, Sinai<br>Health System | <a href="mailto:maria.iliescu@sina i.org">maria.iliescu@sina i.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | CMS should only include reliable and valid measures in the calculation of star ratings, and ensure measure grouping and group weights are balanced and reflect areas of importance for patients.  | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System                 | <a href="mailto:maria.iliescu@sina i.org">maria.iliescu@sina i.org</a>     | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>b. CMS should seek impartial review of the star ratings methodology and broad stakeholder input.</p> <p>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.</p> <p>c. CMS should not publish star ratings until the agency appropriately resolves issues with the methodology.</p> | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System                 | <a href="mailto:maria.iliescu@sina i.org">maria.iliescu@sina i.org</a>     | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>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.</p> <p>We stand ready to work with CMS and others on better ways to empower patients and their families with information about health care quality.</p>                           | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System                 | <a href="mailto:maria.iliescu@sina i.org">maria.iliescu@sina i.org</a>     | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | More generally, we believe that CMS' star ratings, in their current form and even with the proposed changes, should be removed from public view.  | Sameh Samy, MBBCh, MSA, CPHQ, AVP, Quality Management Dept., Maimonides Medical Center | <a href="mailto:APollack@maimonidesmed.org">APollack@maimonidesmed.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | We would add that the methodologies for several of CMS's programs use a variety of sometimes discordant tools which would be confusing to patients and make the ratings problematic without substantial change.  | Sameh Samy, MBBCh, MSA, CPHQ, AVP, Quality Management Dept., Maimonides Medical Center               | <a href="mailto:APollack@maimonidesmed.org">APollack@maimonidesmed.org</a> | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Thank you for the opportunity to comment on the above referenced subject. My hospital is an urban, not for profit, 400 bed hospital in a medically under-served area of NYC. Our patients are 60% Medicaid, 20% Medicare and approximately 5% non-insured (due primarily to their "un-documented status"). We have had significant concerns over the "star ratings" since their inception and the current proposal will only further confuse patients and potentially harm our hospital. | William Lynch, Executive Vice President and Chief Operating Officer, Jamaica Hospital Medical Center | <a href="mailto:BFLANZ@jhmc.org">BFLANZ@jhmc.org</a>                       | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Virginia Commonwealth University Health System, including Medical College of Virginia Hospital (490032), appreciates the opportunity to comment on the CMS Overall Hospital Quality Star Rating. VCU Health System supports transparency in healthcare and in providing the public with information they need to make informed healthcare decisions.</p> <p>In its current form, the CMS Star Ratings are driven by methodology, not actual performance. Therefore, until CMS can establish a sound methodology with appropriate socioeconomic adjustments and peer groupings, VCU Health System strongly urges CMS to suspend the display of Star Rating. Continued promulgation of invalid and meaningless Ratings adds to administrative burden and costs for hospitals and providers and misleads healthcare consumers.</p> <p>Among VCU Health System's primary concerns:</p> <ol style="list-style-type: none"> <li>1. Ratings are driven by methodology rather than actual hospital performance. The complex statistical technique called "latent variable modeling" is widely recognized to be inappropriate for this type of data.</li> <li>2. Star ratings fail to account for social risk factor differences across hospitals, or to provide valid peer groupings for like to like hospital comparisons.</li> </ol> <p>The complex statistical technique called "latent variable modeling" is widely recognized to be inappropriate for this type of data. Analysis of the latent variable modeling used in the Star Ratings has demonstrated the following issues:</p> <p>Wild swings in the loading coefficients every 6 months, though measures should be stable.</p> <ul style="list-style-type: none"> <li>• Hospitals having a 2-3 star change in a one year period due to the statistical model, though there were only slight variations in performance</li> </ul> | <p>Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckley, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality &amp; Safety First Programs; VCU Health System</p> | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>In the un-released July 2018 Star Ratings, the latent variable model produced negative loading coefficients, which actually penalized hospitals, including ours, for having improved performance in some HAI. Latent variable modeling must be abandoned entirely for CMS Star Ratings to be balanced and have value to the public. VCU Health System supports the move to a system of defined measure weights similar to those used by other CMS programs such as Hospital Value Based Purchasing (HVBP) and Hospital Acquired Conditions Reduction Program (HACRP).</p> <p>Given the questionable application and the difficulty in interpreting results from latent variable modeling, VCU Health System urges CMS to remove latent variable modeling from the Overall Hospital Quality Star Rating completely and instead, apply consistent weights for each measure and evaluate weight allocation annually. This would provide scoring stability and easier interpretation for hospitals and the public. VCU Health System believes that meaningful transparency is essential for providers, patients and the public to make the best use of health care information.</p> | <p>Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckley, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality &amp; Safety First Programs; VCU Health System</p> | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>After reviewing requests for comment from CMS, our Data Science team has added more specific comments, which are attached.</p> <p>In closing, VCU Health System believes that meaningful transparency is essential for providers, patients and the public to make the best use of health care information. In theory, star ratings should reflect a balanced view of hospital quality. However, star ratings are based on a flawed latent variable model approach that is not reflective of actual performance, can be disproportionately driven by narrow aspects of care, and do not adjust for complexity of care or socioeconomic factors. CMS's choices of measures and methodology introduce some significant biases into the star ratings; hence, CMS Star Ratings are neither valid nor meaningful.</p> <p>Therefore, until CMS can establish a sound methodology with appropriate socioeconomic adjustments and peer groupings, VCU Health System strongly urges CMS to suspend the display of Star Rating.</p> <p>VCU Health System does not support further adjustments to the latent variable model process. Latent variable modeling is the not the best approach for the data and therefore no matter the adjust ments made for "stability", inconsistency and bias remain. It must be abandoned in favor of creating a defined set of measure weights, similar to VBP/HAC programs and measure group weighting.</p> | <p>Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckely, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality &amp; Safety First Programs; VCU Health System</p> | <p><a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a></p> | Health System         | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>The University of Pittsburgh Medical Center (UPMC) is a world-renowned health care provider, insurer, and academic center of excellence. We are dedicated to the advancement of quality, patient safety, and affordability of healthcare. UPMC operates more than 30 academic, community, and specialty hospitals, more than 600 doctors' offices and outpatient sites, employs more than 4,600 physicians, and offers an array of rehabilitation, retirement, and long-term care facilities. UPMC sincerely appreciates the opportunity to review and comment on the Overall Hospital Quality Star Rating Public Input Request. While we acknowledge the Star Ratings' value as an easily accessible consumer tool for empowering patients in healthcare decision making, we strongly feel that extensive methodology revisions and simplifications are required. It is essential that consumers and providers have access to a fair and transparent hospital rating system, and until this goal is achieved, we respectfully request that the Star Ratings be removed from Hospital Compare until further discussions and developments have occurred.</p> <p>UPMC applauds YNHHS/CORE's efforts around proposing extensive revisions to the Star Rating methodology, however it is difficult to weigh many of these proposals independently without considering how they might impact or even invalidate others. Without a clearer understanding of the interactions between these numerous proposals, there exists the possibility for unanticipated repercussions. With that being said, we recommend the following updates to the Star Ratings methodology:</p> | Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center | <a href="mailto:Panzarellolm@upmc.edu">Panzarellolm@upmc.edu</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We would like to comment on the methodology used by the Centers for Medicare and Medicaid Services for the Overall Hospital Quality Star Rating on behalf of MedStar Health. MedStar Health is the largest healthcare provider in the Maryland and Washington, DC region. MedStar Health includes:</p> <ul style="list-style-type: none"> <li>• 2 academic medical centers (MedStar Georgetown University Hospital and MedStar Washington Hospital Center),</li> <li>• 7 community hospitals (MedStar Franklin Square Medical Center, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center, MedStar St. Mary's Hospital and MedStar Union Memorial Hospital), and</li> <li>• 1 rehabilitation hospital (MedStar National Rehabilitation Hospital).</li> </ul> <p>Based on our internal analysis, an analysis performed by our national data comparison partner (Vizient Inc) the Advisory Board, and others, we have growing concerns related to the CMS Hospital Quality Star Rating Methodology. Our system is specifically impacted by the instability and lack of transparency of the Latent Variable Model, the apparent bias of the methodology against larger tertiary-care hospitals and the apparent bias of the methodology against hospitals caring for socioeconomically disadvantaged patients.</p> <p>The black box nature of the Latent Variable Model makes it very difficult for hospitals to predict the impact of quality improvement activities and possibly the attainment of a higher Hospital Summary Score for actual improvements. As shown in the June 2018 Overall Hospital Quality Star Rating Results release, the regularly and heavily weighted PSI-90 metric showed a dramatic decline from 0.94 to 0.17, returning to 0.90 during the February 2019 release.</p> | <p>Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health</p> <p>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health</p> | <a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Simultaneously, the Total Hip Arthroplasty and Total Knee Arthroplasty Complication metric showed the opposite behavior. It is very difficult for hospitals to identify high priority areas for improvement, related to the Stars Program, when weightings are inconsistent and the inconsistency is considered part of the model.</p> <p>An analysis performed by The Advisory Board and Rush University Medical Center indicted a hospital size may influence the Star Model because of the effect of volumes, causing larger hospitals to spread out to the ends of the Star distribution while smaller hospitals cluster towards the middle of the Star distribution. Rush University Medical Center found that the Large Hospital category had a larger percentage of 1 and 5 Star Hospitals (12.6% and 10.5% respectively) when compared to the Medium Hospital category (5.6% and 6.4%) and the Small Hospital category (0.0% and 4.9%). This pattern is reflected among the hospitals in the MedStar Health System, with our lowest volume hospitals cluster in the middle of the Star distribution and our higher volume hospitals at the ends of the distribution.</p> <p>Additionally, Rush University Medical Center analyzed Star Ranking by socioeconomic status (SES) assigned to hospitals as part of the CMS Hospital Readmission Reduction Program (HRRP). Their findings revealed that the percentage of 5 Star Hospitals increased with the higher SES Level while the percentage of 1 Star Hospitals increased for the lower SES Level. This finding may indicate that the Star Methodology negatively impacts inner city hospitals, trauma centers, and tertiary hospitals. These hospitals often treat a larger proportion of lower income/uninsured patients as well as accepting transfers from neighboring hospitals. Where the impact of SES Levels on MedStar Health hospitals is not as clear, two of the three 1 Star Hospitals in the MedStar Health System are tertiary hospitals, with one designated as a trauma center. The third 1 Star Hospital, while not a tertiary hospital, is classified as a lower SES Level.</p> | <p>Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health</p> <p>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health</p> | <a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | With the above-mentioned deficits, in addition to others not addressed in this letter, we can definitively conclude that the Star rating methodology does not achieve the aim of a transparent measure of quality and safety that is easily and accurately understood by consumers or healthcare leaders. The current methodology therefore does not support a hospital or healthcare system's improvement activities because of the model's lack of stability and the inclusion of factors beyond control of the individual hospital such as hospital volume and sociodemographic disadvantages of certain patient populations. The Star ratings methodology inadvertently penalizes large hospitals and academic medical centers.                                     | Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health<br>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health     | <a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a>       | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | MedStar Health has built our quality and safety values on the principle of transparency, and we support the release of valid measures of quality care to the public. However, it is counterproductive to release ratings that misrepresent the actual quality of care provided, and this is particularly damaging to the nation's public health if this misrepresentation hurts the hospitals most which take care of disadvantaged and most needy patients. Thus, we are very pleased that CMS is evaluating the Overall Hospital Quality Star Rating Program methodology and are considering taking steps to ensure the stability of the scoring process while also taking into consideration adjustments for factors outside of an individual institution's control. | Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health<br><br>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health | <a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a>       | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | In a recent working paper, “An Efficient Frontier Approach to Scoring and Ranking Hospital Performance” (2019), I develop a new approach to replace the Latent Variable Model (LVM) used in the CMS Hospital Star Ratings. I believe my work offers answers to or resolves many of the questions posed as part of this Public Input Request. In this document, I will focus on these. You may find my paper posted on SSRN at <a href="https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3359552">https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3359552</a> and attached. I will assume that you are familiar with its contents.  | Dan Adelman, Professor, University of Chicago Booth School of Business   | <a href="mailto:Dan.Adelman@chicagobooth.edu">Dan.Adelman@chicagobooth.edu</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | One of our users from our internal focus group suggested that CMS should provide a measure group/domain rating for each domain and an overall star rating. If you used a system similar to computing Overall Hospital Quality Star Ratings, they said this would provide the consumer guidance that is more direct.   | Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System  | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a>     | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Thank you for the opportunity to provide feedback on the underlying methodology and potential updates of the Overall Hospital Quality Star Ratings presented on the Hospital Compare website. Our response to the questions posed is presented below:   | Jean Cherry, FACHE, Executive Vice President, Med Center Health                | <a href="mailto:jean.cherry@mchealth.net">jean.cherry@mchealth.net</a>         | Healthcare System      | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Thank you for the opportunity to provide comments on CMS' proposed changes to the Star Ratings methodology. Olathe Medical Center is a 300-bed community hospital in Olathe, Kansas; a suburb of Kansas City. Olathe Medical Center is an independent, private, non-profit health care organization.</p> <p>Olathe Medical Center appreciates CMS' effort to reevaluate the STAR ratings. However, we are disappointed that the Star ratings continue to be publicly available while the methodology is being developed, modified, and reevaluated. Olathe Medical Center is a committed partner in healthcare with our community and our public reputation is extremely important to those we serve. We believe the Star methodology is flawed and does not provide our community with accurate information regarding the quality of health care services available to them in their community.</p> <p>Single overall rating - We applaud CMS' efforts to enhance the validity of the Star Ratings and we strongly support the goal of making data on Hospital Compare easier to understand. We also concur with statements made by the Kansas Hospital Association that one overall rating for each hospital may not provide patients with meaningful information regarding specific care that they need. A single rating may not capture information regarding an area of expertise that most important to a patient. Olathe Medical Center believes that ratings by topic or specific clinical condition would be more useful to consumers. Further, the complexity of the methodology that results in an overall star rating is not easily understood even by experts in the field and is nearly impossible for most consumers to understand.</p> | Cathy Wiens, MHA, Vice President/Quality and Compliance; Olathe Medical Center | <a href="mailto:cathy.wiens@olathehealth.org">cathy.wiens@olathehealth.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Olathe Medical Center supports the goal of providing consumers meaningful and accurate quality data in a transparent way. Olathe Medical Center believes the Star Ratings should be suspended until there is adequate time for stakeholders to understand the current methodology and the proposed changes and for CMS to continue to work on the validity of the Star Ratings system. Additional time and information is needed for stakeholders such as Olathe Medical Center, an independent community hospital, to understand and provide meaningful input for such a complex program that has significant implications for our community and providers.</p> <p>Thank you for the opportunity to provide feedback.</p>  | Cathy Wiens, MHA,<br>Vice President/Quality and Compliance;<br>Olathe Medical Center | <a href="mailto:cathy.wiens@olath.ehealth.org">cathy.wiens@olath.ehealth.org</a> | Hospital                 | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>In late February, 2019, the Centers for Medicare &amp; Medicaid Services ("CMS") published updated star ratings for hospitals on the Hospital Compare website. In connection with that publication, CMS requested that stakeholders and the general public offer input regarding the Overall Hospital Quality Star Rating Program ("Star Rating Program"), including several specific proposals under CMS consideration for future updates. By this letter, Carthage Area Hospital ("Carthage") hereby responds to this request for public input as follows: Carthage wishes to thank CMS for the opportunity to provide input into the overall design and structure of the Star Rating Program. As discussed in more detail below, Carthage believes that CMS should:</p> <ul style="list-style-type: none"> <li>• Adopt a peer group system for the Star Rating Program, such that hospitals are appropriately compared with one another based on similar resources, patient load, and regulatory quality reporting requirements;</li> <li>• Ensure the public is appropriately informed regarding key differences between these peer groups, including rural/urban location, bed size, patient volume, availability of resources, and other key distinguishing characteristics; and</li> <li>• Create a different measure grouping/methodologies for providers who operate in different quality programs (e.g., rate critical access hospitals on MBQIP measures, rather than on inapplicable quality programs)</li> </ul> <p>Adopting these changes will help CMS ensure that the Star Rating Program:</p> <ul style="list-style-type: none"> <li>• Provides accurate comparison points for consumers to consider related to hospital quality;</li> </ul> | Rob Bloom, CFO;<br>Carthage Area Hospital  | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a>                           | Critical Access Hospital | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>• Mitigates harm suffered by small, rural or critical access hospitals as a result of potentially inaccurate and misleading quality results;</li> <li>• Mitigates misleading fluctuations in star ratings for hospitals that have relatively low patient volume;</li> <li>• Improves the overall reliability and usefulness of the Star Rating Program</li> </ul> <p>Carthage Area Hospital is a critical access hospital located in Carthage, New York. In addition to serving as a focal point for health care services in Jefferson and the surrounding counties, Carthage serves as the primary off-site source of health care services for Fort Drum, home of the Army's 10 Mountain Division. Carthage is the primary provider of inpatient, outpatient, and emergency medical services for its community, and also offers a comprehensive suite of ancillary services, including behavioral health, primary care, obstetrics and gynecology, school-based health clinics, and other specialty care.</p> <p>Carthage strives to provide high quality care for its patients. Through its participation in the FLEX Program, the Medicare Beneficiary Quality Improvement Project, and other rural hospital grant programs, Carthage tracks and reports a wide range of quality data related to its operations. Carthage believes it is important that hospitals strive for continual improvement in these areas, and the consumers have accurate, representative information upon which to base informed care choices.</p> <p>As a preliminary matter, Carthage supports CMS' overall drive towards the enhancement of value-based care, concern over the quality of services furnished at hospitals across the country, and the availability of information for consumers to make educated, reasoned decisions regarding their care. Carthage wishes to thank CMS for the energy and momentum it has demonstrated in this regard over the past few years. That said, Carthage is responding to CMS' public input request because the Star Rating Program, as currently devised and implemented, does not serve these goals as to small, rural hospitals - in particular facilities designated as critical access hospitals ("CAH(s)").</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>The Star Rating Program is a CMS invention-it is not mandated, required, or guided by any statute or regulation. Rather, CMS has adopted the Star Rating Program from program designs and methodologies it is required to use in other contexts (e.g., Medicare Advantage plans and nursing home quality) for the purpose or providing similar information to consumers regarding hospital care, thus arming consumers with key quality indicators for the facilities at which they may seek care. Although the aim is laudable, without proper implementation the Star Rating Program does not serve these lofty goals, and actually negatively impacts consumers' ability to make educated decisions regarding patient care. Moreover, the impact CMS star ratings have on CAHs is real, and can carry devastating consequences for rural providers that rely on close relationships with their host communities.</p> <p>In designing the Star Rating Program, CMS relied heavily on measures and methodologies drawn from existing hospital quality reporting programs, including the Hospital Inpatient and Outpatient Quality Reporting Program ("IQRP/OQRP"), Hospital Value-Based Purchasing Program ("HVBP"), and Hospital Readmission Reduction Program ("HRRP"), amongst others. This reliance is understandable, as CMS had the infrastructure and process already in place to draw down data from these programs, whether through hospital uploads to QualityNet or the submission of infection information to NHSN, the Center for Disease Control's infection database.</p> <p>The problem, however, is that CAHs are not required to participate directly in any of these programs. Rather, CAHs' primary quality reporting obligations are through the Medicare Beneficiary Quality Improvement Project ("MBQIP"), which is a CMS-driven quality reporting program designed specifically for CAHs and in which 96% of CAHs participate to some degree. There is little overlap between the quality measures CMS has selected for the Star Rating Program, and the measures CAHs are required to report through MBQIP. Where CAHs do participate indirectly in IQRP or other quality reporting programs, or use these programs' infrastructure, their participation generally relates only to a portion of the quality measures these programs cover. Consequently, the Star Rating Program is premised on quality measures designed to be tracked and reported by larger acute care facilities.</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>The design choice to focus on acute care hospitals carries through to other components of the Star Rating Program methodology. For example, when a hospital does not have sufficient data for CMS to score at least three separate measures within a given measure domain (e.g., Safety of Care), CMS redistributes the weight assigned to that domain in accordance with its methodology for HVBP - a program designed for acute care hospitals. This design choice also impacts smaller hospitals, as reassigned weights may place greater emphasis on measures that disproportionately impact hospitals with small patient volumes. For example, if additional weight is placed on mortality and readmission measures, CAHs, which by definition will have smaller patient volumes, will be at greater risk of negative rating outcomes on the basis of a very small number of actual cases.</p> <p>The Star Rating Program's control mechanisms include suppression of hospital scores when CMS is unable to aggregate enough data for a given facility to produce what it considers to be a reliable star rating. Currently, CMS must have enough data to produce scores for at least three measures within three measure domains in order to produce a star rating. If a hospital does not hit these thresholds, then CMS does not assign a star rating to that hospital. Because CAHs have low patient volumes, and are not required to report a significant portion of the quality measures that otherwise inform the Star Rating Program, CAHs are often on the border or below the threshold necessary to assign a star rating. For example, of the 18 CAHs in the State of New York, 9 were not assigned a star rating for the most recent update period.</p> <p>The Star Rating Program is already an over-simplification of hospital quality ratings - condensing quality of care across all service lines and offerings at a given hospital to a single, one through five star rating necessarily glosses over a trove of data that could (and should) be important to consumer decision-making. This is particularly true for CAHs, as there is greater disparity in the service offerings offered by these facilities based on geographic, economic, community need, and other factors.</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>In addition to weighing a hospital 's star rating, consumers must also weigh and make an informed judgment between facilities where one hospital may have received a low star rating and a hospital that did not produce enough data to receive a star rating in the first place. Informed consumer judgment is nearly impossible under these circumstances, but where consumers are faced with decisions between rural health care facilities these consumers must have reliable information. The Star Rating Program cannot serve its intended purpose when these information gaps exist.</p> <p><b>Recommendations</b></p> <p>To address the concerns of small, rural hospitals, including CAHs, there are a number of potential options that CMS should consider. These options are not all mutually exclusive, and the correct path forward may involve implementation of more than one of the options outlined below. Carthage offers these suggestions in a spirit of collaboration with CMS, and welcomes the opportunity to work with CMS to develop one or more of the alternatives outlined below:</p> <p>A. Remove CAHs from the Star Rating Program. The simplest fix would be for CMS to remove CAHs from the Star Rating Program. This option recognizes that the Star Rating Program was built and designed for large acute care hospitals, and that those facilities are an appropriate focus for CMS efforts. This removal could be permanent, or temporary, depending on CMS' willingness and ability to develop a methodology designed with CAH resources and limitations in mind.</p> <p>B. Allow CAHs to Opt Out of the Star Rating Program. As an alternative, CMS could allow CAHs the opportunity to opt out of the Star Rating Program. This would serve CMS' purpose of assigning a star rating to as many hospitals as possible, while allowing CAHs some level of control over quality-related concerns and the ability to account for individual aberrant outcomes.</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | As currently designed and implemented, the Star Rating Program does not serve CMS' purpose or intent with respect to CAHs. The Star Rating Program was designed for large acute care hospitals, and does not take into account the unique facts, circumstances, and legal requirements that apply to CAHs. To address these issues, CMS should take steps to modify the Star Rating Program in line with the recommendations outlined above. Carthage appreciates the opportunity to dialogue with CMS regarding these issues, and would welcome the opportunity to engage directly with CMS and its contractors to discuss updates to the Star Rating Program. Should CMS have any questions regarding the content of this comment, please reach out to me by phone at (315) 519-5202 or by email at rbloom@calmy.org.  | Rob Bloom, CFO;<br>Carthage Area Hospital  | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a>                           | Critical Access Hospital                   | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Vizient, Inc. appreciates the opportunity to respond to the request for public comment from the Centers for Medicare and Medicaid Services (CMS) to gain feedback from stakeholders on several potential updates to, and future considerations for, the methodology of the Overall Hospital Quality Star Rating on Hospital Compare. We respectfully submit our comments regarding the specific topics that address changes in hospitals' Overall Hospital Quality Star Ratings. Vizient is pleased to provide input on the agency's plans for longer-term, potential future directions for the Overall Hospital Quality Star Ratings. Vizient is the nation's largest health care performance improvement company. Our mission is to strengthen our members' delivery of high-value care by aligning cost, quality and market performance. Vizient is member-driven and member-minded, working tirelessly to amplify each organization's impact by optimizing every interaction along the continuum of care. We serve a diverse membership including academic medical centers, pediatric facilities, community hospitals, integrated health delivery networks and non-acute health care providers. Vizient is headquartered in Irving, TX with locations in Chicago, Washington, D.C., and other cities across the country. | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>People rely on statistical modeling to provide objective assessments about data and to guarantee a level of certainty that the results are simply not due to random chance. To ensure this statistical objectivity is upheld, researchers, data scientists and statisticians must evaluate whether the data and the results meet the necessary modeling requirements; otherwise, like looking in a funhouse mirror, the results become distorted, unstable and less dependable.</p> <p>Since 2005, Vizient has been using patient data, statistical modeling and outcomes analysis to bring reliable and actionable insights to our member hospitals and their clinicians to help them understand their performance and identify areas where improvement is necessary. Our annual Quality and Accountability Ranking measures performance based on the Institute of Medicine's (IOM's) six domains of care: safety, timeliness, effectiveness, efficiency, equity and patient centeredness. Vizient utilizes a composite scoring system for ranking, which uses current, patient-level performance data from a variety of public sources, including the CMS Core Quality Measures and the Vizient Clinical Data Base1. In 2018, nearly 400 hospitals participated in the study.</p> <p>Given Vizient's experience and expertise in analyzing data and rating hospitals in performance measures, the introduction of CMS' Overall Hospital Quality Star Ratings in 2016 was welcomed as another mechanism to help drive performance improvement, while also serving as a resource for patients. Since their introduction, Vizient has been analyzing each update to determine if the methodology used by CMS is meeting the goal of statistical objectivity. Based on the results of our assessments, Vizient has continued to express our concerns that the current methodology is providing unstable results, and has shared these findings and recommendations with the agency.</p> <p>Furthermore, Vizient urges CMS to remove the publication of the Star Ratings from the Hospital Compare website until the agency addresses significant concerns with the methodology. In doing so, we hope you will consider the recommendations detailed below as well as other, expert feedback regarding the current methodology.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>In our comments, Vizient provides specific responses to various issues raised regarding the proposed enhancements to the Overall Hospital Quality Star Rating, as well as the current methodology used in calculating hospital scores. We offer our feedback and recommendations to constructively improve the Overall Star Rating project. Our comments reflect the views of our organization, as well as input received from our hospital members from across the nation.</p> <p><b>Confusing Results Created by the Current 1-Factor Latent Variable Model Approach</b></p> <p>Given the confounding results produced by CMS’ latent variable modeling approach, Vizient conducted an in-depth statistical assessment to better understand the methodological issues. CMS currently uses what is known as a 1-factor, weighted latent variable modeling approach, which simply assigns a single weight to each measure. More complex approaches exist, such as 1-factor reduced measures – which only includes measures that are statistically significant – or 2-factor modeling – which assigns two measures weights for a single measure. Vizient closely examined four common model fit statistics used in evaluating latent variable modeling performance, and identified model fit performance opportunities across 4 of the 7 measure groups.</p> <p>One common model fit statistic, the goodness-of-fit test, assesses how well the latent variable model-generated results compare with the observed data. When simulating model performances 100 times and assessing the goodness-of-fit results, Vizient identified model problems with six of the seven measure groups. The root mean square error approximation is another technique for assessing model performance where a small error value is desirable; however, both the patient experience and the process timeliness groups indicate larger than acceptable model error values.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Another model performance evaluation, the comparative fit index, assesses if the model performs consistently with the observed values. For the February 2019 data, six of the seven groups indicated poor performance with less than 0.95 performance. Lastly, the standardized root mean square residual measure evaluates differences between the actual observed data compared to the model's output. Based on this assessment, Vizient found that four of seven measure groups indicate opportunity for improvement. The combined assessment across all measures can be found below in <a href="#">[Table 3]</a>.</p> <p>To gain insight into how CMS could potentially improve the latent variable modeling approach, Vizient explored alternative, more complex latent variable modeling approaches to improve model performance – including 1-factor-reduced measures, 2-factor and 2-factor-reduced measures modeling approaches. Vizient found through the various modeling approaches that, while model performance improved per the four model fit statistics referenced, the increased model complexity resulted in lower user interpretability. While these more complex approaches may be more statistically appropriate than the current CMS 1-factor latent variable modeling approach, the additional complexities intrinsically linked would make it even more difficult for the public and providers to understand.</p> <p><b>Pay-for-Performance Measures and Star Ratings Yield Inconsistent Results</b></p> <p>CMS sets the nation's standards for health care performance evaluation through their pay-for-performance strategy and programs. The measures included in the Hospital Value-Based Purchasing Program (VBP), Hospital-Acquired Conditions Reduction Program (HACRP) and Hospital Readmissions Reduction Program (HRRP) all financially penalize hospitals who do not meet CMS-established performance thresholds.</p> <p>The measures used in these pay-for-performance programs also contribute significantly to the Overall Hospital Quality Star Ratings – in particular the Readmission, Safety, Patient Experience and Mortality group scores. These groups collectively represent 88 percent of the overall score; however, despite the overall measure alignment, the results between the pay-for-performance and the Star Ratings are inconsistent.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>For example, for the fiscal year (FY) 2019 VBP measure noted in s, 1,229 hospitals received a financial penalty for performance <a href="#">[Table 4]</a>. Of those, 452 hospitals received an ‘Above the National Average’ classification for the Safety group, 105 hospitals received ‘Above the National Average’ for the Mortality group, and 151 hospitals received ‘Above the National Average’ for the Patient Centeredness group in the Star Ratings program. Further, of the 2,587 hospitals who received a payment penalty in the HRRP, 945 hospitals also received ‘Above the National Average’ for the Readmission group in their Star Rating.</p> <p>Vizient believes this is due to methodological differences between the two CMS-supported programs. For the HRRP, CMS evaluates hospitals using quintile binning based on the percent of dual-eligible Medicare payers; whereas, for the CMS Star Rating Readmission group score, no adjustment is made. This disconnect in methodology between the two programs is not only financially penalizing providers, but also affecting the reputation hospitals have worked diligently to earn in each of their communities. Furthermore, it adds to public confusion as to which hospitals are providing the best quality care.</p> <p>At the individual measure level, the methodological inconsistencies also appear. In the December 2017 Hospital Star measure loading coefficients as shown below in <a href="#">[Table 5]</a>, the latent variable modeling approach deemed HAIs as non-statistically significant loading coefficients – yet important enough to put hospitals at financial risk for poorer performance.</p> <p>Vizient found similar results as shown for the February 2019 Safety measure loading coefficients with non-significant p-values for central-line associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI). To rectify these issues, Vizient recommends CMS take a consistent hospital evaluation approach by first assessing the precedents CMS has set in existing pay-for-performance programs, and aligning and streamlining them with the Star Rating methodology.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>Many of the heavily weighted CMS measures, such as the measures in the readmissions, safety and mortality groups are considerably dated, some going as far back as 2014 for the collected measures reported in the February 2019 CMS Hospital Star Ratings. Vizient continues to believe that the current CMS Star Ratings do not reflect current hospital performance, which limits the usefulness of the Star Ratings for patients making health care choices. Furthermore, placing increased weights on these measure groups containing two-year old performance data is misleading to the public by not accurately reflecting the current performance, or as close to current performance data as possible, for measures that are highly visible and of high importance to patients.</p> <p>Additionally, because the Star Ratings leverage Medicare data, which represents approximately 10-15 percent of a hospital's total patient population, it primarily focuses on conditions and procedures for the 65 years or older patient populations. Vizient applied our recommended approach of grouping hospitals to the CMS February 2019 data. Additionally, we removed critical access and specialty hospitals from the assessment and weighted the measures equally. In comparing the February 2019 CMS to the Vizient Hospital Groupings, AMCs are more evenly represented in the 4 and 5 Star Ratings <a href="#">[Figure 1]</a>, and Complex Teaching Medical Centers and Community hospitals have only a slight adjustment in Star Ratings <a href="#">[Figure 2]</a>. Vizient believes that this approach provides a more practical, comparable assessment of hospital performance that limits bias due to limited measure representation or differences in full hospital patient acuity.</p> <p><b>Conclusion</b></p> <p>Vizient appreciates the opportunity to provide feedback on the Overall Hospital Quality Star Rating, and to inform the agency on how the methodology is impacting our members. We look forward to continuing to work with CMS to ensure patients and providers have access to reliable information. Vizient is encouraged that CMS has taken steps to seek additional input in order to deliver a better Star Ratings program, and looks forward to providing continued feedback and support.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>In health care, patients expect reliable, consistent, high quality and scientifically based care to improve their quality of life. Health care providers expect the same when being measured for the care they deliver, while also seeking data and insights to drive continuous quality improvement. However, the current CMS Star Rating program falls short of these expectations by evaluating hospitals with methods, scoring incentives and data sets that do not portray an accurate or complete picture and include heterogeneous hospital comparisons which currently are misaligned with CMS' pay-for-performance programs.</p> <p>Vizient supports CMS considering a more consistent weighting schema, for example as used in existing programs – while creating hospital cohorts that provide fair and meaningful performance evaluations. Additionally, Vizient strongly encourages CMS to explore leveraging more current data to provide more actionable and meaningful Star Ratings for performance improvement. We advocate for changes to the system that will support the core mission of the CMS Hospital Quality Star Rating of providing patients and the public with a clear, simple and objective mechanism for identifying top hospitals.</p> <p>Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers.</p> <p>In closing, on behalf of Vizient, Inc., I would like to thank CMS for providing us this opportunity to comment. Please feel free to contact me at (202) 354-2600 or Chelsea Arnone, Director of Regulatory Affairs and Government Relations (chelsea.arnone@vizientinc.com), if you have any questions or if Vizient can provide any assistance as you consider these issues.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 165,000 other providers and organizations, we appreciate the opportunity to submit comments regarding the Overall Hospital Quality Star Rating for Hospital Compare Public Input Request. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Additionally, Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in the efficacy of the CMS star rating.</p> <p>The Overall Hospital Quality Star Rating fails to provide patients and their families with an accurate representation of quality in order to appropriately inform their decision on where to seek care. Furthermore, the lack of transparency in the latent variable model used prohibits providers from understanding their score and identifying opportunities for improvement. CMS must adopt a transparent overall hospital quality star rating that can be easily interpreted by consumers and replicated by hospitals. We are encouraged that CMS is seeking comment on several potential updates including overhauling the existing star rating methodology. CMS should remove the star rating from Hospital Compare while it works to develop a more transparent methodology. Below, the Premier healthcare alliance provides detailed comments with suggested modifications to the star rating methodology.</p> <p>CMS has developed or sought comment on star ratings for a variety of providers and clinicians. While our comments are specific to the Hospital Compare star rating, CMS should consider these principles for the development or revision to any other star ratings.</p> <p>Based on the observed randomness of the safety of care domain, we recommend the CMS reduce the weight of the safety of care domain and weight domains with more stable properties heavier.</p> | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Overall Hospital Quality Star Rating for Hospital Compare Public Input Request. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, senior director, payment and quality policy, at aisha_pittman@premierinc.com or 202.879.8013.   | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance                                       | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | Massachusetts General Hospital (MGH) is a strong supporter of transparency in healthcare performance measurement and applauds the efforts of CMS to make hospital quality data accessible and intuitive to consumers. We thank CMS for this opportunity to provide input to the Overall Hospital Quality Star Ratings methodology and the most recent proposed changes.<br>MGH would like to make several recommendations regarding CMS's Public Input Request. MGH has organized our responses into the following three categories: explicit approach vs latent variable modeling, peer grouping, and other proposals. Thank you for the opportunity to comment on important changes to the CMS Overall Hospital Quality Star Ratings methodology. At MGH, we strongly support efforts to provide consumers with transparent, meaningful and actionable data, and we are happy to discuss this recommendation in greater detail.  | Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital | <a href="mailto:emort@partners.org">emort@partners.org</a>                     | Medical University                              | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We greatly appreciate the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) on the February 2019 Overall Hospital Quality Star Rating on Hospital Compare Public Input Request.<br>The FAH appreciates CMS's Public Input Request on potential future methodology changes being considered for the Medicare Hospital Star Ratings program as well as the ongoing efforts to improve the star ratings methodology. It is vitally important to hospitals, patients, their families and the overall national work on quality improvement and public reporting that any changes to the display of data by star categories accurately reflect the quality of care provided by hospitals to their patients. | Chip Kahn, President, CEO, Federation of American Hospitals   | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a>                       | Hospital Association                            | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The FAH applauds CMS’s recognition for the opportunity of a much needed refresh as we continue to hear from our members that, beyond the ongoing methodological issues, a single graphical representation of hospital care using a limited number of measures which are variably reported across hospitals cannot reflect all aspects of hospital care and may mislead the public for whom the tool is intended as a helpful guide.</p> <p>Moreover, the FAH continues to have reservations about the Star Ratings methodology as the measures it leverages were not developed with the intent to be displayed as part of a composite. In addition, while the statistical methods used to derive the ratings may work well in an exploratory and research capacity, the FAH does not believe application of these methods to generate a rating to which organizations will be held accountable is prudent. Accountability demands a clear performance target, and not only do the Star Ratings rely on cut-points that are unknown to hospitals in advance they also fluctuate widely. This type of moving target poses challenges to hospitals’ understanding of CMS’s specific quality performance goals.</p> <p>The FAH urges CMS to consider alternative ways to construct and present star ratings and to suspend the Star Ratings from the Hospital Compare website until concerns with the methodology have been addressed. At a minimum, the methodology should be transparent, understandable, have clear cut-points and targets, and accurately reflect the quality of care provided in the facilities.</p> <p>To help achieve that goal, the FAH continues to urge CMS to form an additional Technical Expert Panel (TEP) or outside expert group composed of statisticians and biostatisticians who can supplement much needed understanding of the various assumptions and limitations inherent in latent variable modeling (LVM).</p> <p>Our comments on the specific methodology updates under consideration follow. The FAH appreciates the opportunity to comment on the options and proposals to move to an improved Overall Hospital Quality Star Rating. If you have any questions regarding our comments, please do not hesitate to contact me or Claudia Salzberg of the FAH staff at (202)624-1500.</p> | Chip Kahn, President, CEO, Federation of American Hospitals | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>On behalf of SSM Health, a non-profit integrated health system headquartered in St. Louis, I am submitting formal comments relative to the Centers for Medicare and Medicaid Services (CMS) request for comment on the Overall Hospital Quality Star Rating on Hospital Compare.</p> <p>For background purposes, SSM Health is the sixth largest Catholic Health System in the United States. Our organization's more than 40,000 employees and 10,000 providers are committed to providing exceptional health care services and revealing God's healing presence to everyone they serve. With care delivery sites in Illinois, Missouri, Oklahoma and Wisconsin, SSM Health is one of the largest employers in every community it serves.</p> <p>SSM Health believes strongly in transparency in both cost and quality in health care. Efforts by CMS to provide information to the customers is admirable; however, we believe that the Hospital Quality Star Rating on Hospital Compare can provide misleading and inaccurate information. Therefore we appreciate CMS and their efforts to solicit input from stakeholders.</p> <p>We believe the Hospital Quality Star Rating on Hospital Compare can be changed by doing the following:</p> <p>The star rating process is not an apples to apples comparison from hospital to hospital. There is no incentive to report more measures in the process, and hospitals that fail to provide a measure(s) will have those measures reweighted.</p> <p>We respectfully request that measures have consistent scores and weights and that there isn't an incentive for reporting less measures.</p> <p>Thank you again for requesting feedback on the Hospital Quality Star Rating on Hospital Compare. Should you have any questions or comments, please do not hesitate to ask.</p> | Michael D. Richards, System Vice President, Government Affairs and Public Policy; SSM Health | <a href="mailto:Michael.richards@ssmhealth.com">Michael.richards@ssmhealth.com</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>The Association for Professionals in Infection Control and Epidemiology (APIC) wishes to thank the Centers for Medicare &amp; Medicaid Services (CMS) for the opportunity to provide feedback on efforts to update the Hospital Quality Star Rating System on Hospital Compare. APIC is a nonprofit, multidisciplinary organization representing 16,000 infection preventionists whose mission is to create a safer world through prevention of infection. Our members work to prevent healthcare-associated infections (HAIs) and educate healthcare providers and the public about patient safety. Our comments on the hospital star rating system emphasize the need for this system help patients and consumers make informed decisions about their healthcare choices.</p> <p>APIC agrees with the statement in the Public Input Request that this material is very technical and challenging for stakeholders to interpret. Our concern is that this complexity will result in information for patients and consumers that is either unhelpful or misleading. We agree that the program needs reconsideration of its approach. We also recommend reconsideration of its intent. The CMS report notes that the original approach was to include as many measures as possible; measures are then grouped together by defined criteria. However, this seems inconsistent with the CMS “Meaningful Measures” initiative to reduce measures to those necessary to provide the best quality of care. Measures used to direct meaningful improvements in patient care do not necessarily translate well into useful information to direct patient choice.</p> <p>APIC does not support providing data that is not current for use by the public for hospital comparisons.</p> <p>APIC recognizes the difficulty of developing a measure rating system that reflects a true measure of quality. However, we encourage CMS to refrain from projecting data that is more likely to confuse than assist the public, possibly creates fear for a patient that may not understand the data limitations, and provides no direction for improvement strategies, nor recognizes the intense improvement efforts that exist in our organizations today. Cohesive, meaningful, streamlined measurement programs and approaches must be developed, and we must avoid the use of intense technicality that prohibits understanding of methodology.</p> | Karen Hoffmann, RN, MS, CIC, FSHEA, FAPIC, President; Association for Professionals in Infection Control and Epidemiology | <a href="mailto:nhailpern@apic.org">nhailpern@apic.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | Thank you again for the opportunity to comment. We look forward to continuing to work with CMS on improving healthcare quality and providing patients with safe care and tools to help them make informed healthcare choice.  | Karen Hoffmann, RN, MS, CIC, FSHEA, FAPIC, President; Association for Professionals in Infection Control and Epidemiology | <a href="mailto:nhailpern@apic.org">nhailpern@apic.org</a>                 | Professional Association | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | Christiana Care Health System respectfully submits our comments on the Centers for Medicare and Medicaid Services' (CMS) Hospital Compare Overall Star Rating methodology.  | Delilah Greer, MPH, Director of Data Informatics and Analytics; Christiana Care Health System                             | <a href="mailto:dgreer@christianacare.org">dgreer@christianacare.org</a>   | Healthcare System        | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Dartmouth-Hitchcock Health appreciates the opportunity to submit comments in response to the public input request to provide feedback on potential updates and future consideration for the methodology of the Overall Hospital Quality Star Rating on Hospital Compare, issued by the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>Dartmouth-Hitchcock Health is proud to be New Hampshire's only academic health system, committed to providing all of our patients with high quality care. We serve a regional population base of 1.9 million in New Hampshire, Vermont and across New England, providing access to more than 1,400 primary care doctors and specialists in almost every area of medicine. The health system includes Dartmouth-Hitchcock Medical Center, our flagship hospital in Lebanon, as well as member hospitals in Lebanon, Keene, New London and Windsor, Vermont. As one of the few academic medical centers in a rural setting, Dartmouth-Hitchcock is classified as both a Rural Referral Center and Sole Community Hospital.</p> | George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health   | <a href="mailto:George.t.blike@hitcock.org">George.t.blike@hitcock.org</a> | Healthcare System        | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology | <p>Dartmouth-Hitchcock Health is home to the Norris Cotton Cancer Center, one of only 49 NCI-designated comprehensive cancer centers in the country – the Children’s Hospital at Dartmouth-Hitchcock, the Visiting Nurse and Hospice for Vermont and New Hampshire, and 24 clinics across the region that provide ambulatory services in their communities. Dartmouth-Hitchcock trains nearly 400 residents and fellows each year and performs world class medical research in partnership with the Geisel School of Medicine at Dartmouth. We are the largest private employer in New Hampshire, employing over 13,000 Granite Staters. Dartmouth-Hitchcock Health appreciates CMS’s interest in engaging stakeholders to update the methodology utilized for the Overall Hospital Quality Star Rating program. We have long been advocates of providing transparent, patient-friendly data and information related to quality of health care. However, we remain very concerned about the validity and usefulness of the star rating system for consumers because of the current approaches utilized for calculating hospital summary scores. In this letter, we provide feedback on five of the methodologies employed, including: (1) peer grouping; (2) measure precision; (3) period to period shifts; (4) incorporation of improvement; and (5) user-customized star rating. Thank you for the consideration of these comments. Please contact me at (603) 650-8778 or George.T.Blike@hitchcock.org with any questions.</p> | George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health | <a href="mailto:George.t.blike@hitchcock.org">George.t.blike@hitchcock.org</a>       | Healthcare System      | Please refer to the Summary Report |
| 3/29/19     | Overall Project & Methodology | <p>On behalf of the Adventist Health Policy Association (AHPA) we appreciate the opportunity to comment on the proposed methodology enhancements for the Overall Hospital Star Rating System. Our organization of five Seventh-day Adventist affiliated health systems includes 84 hospitals and more than 300 other health facilities in 17 states and the District of Columbia. AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. Below, please find AHPA’s comments and recommendations in response to the Public Input Request. Specifically, we comment on the following issue areas:</p> <ul style="list-style-type: none"> <li>• Measure Grouping</li> <li>• Regrouping of Measures</li> <li>• Incorporating Measure Precision</li> </ul>   | Carlyle Walton, FACHE, President; Adventist Health Policy Association   | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System      | Please refer to the Summary Report |



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| 3/29/19     | Overall Project & Methodology | <ul style="list-style-type: none"> <li>• Period-to-Period Star Ratings Shifts</li> <li>• Peer Grouping</li> <li>• Closed-Form Solution</li> <li>• Explicit Approach to Calculating Overall Hospital Quality Star Ratings</li> <li>• Alternatives to Clustering</li> <li>• Incorporation of Improvement</li> <li>• User-Customized Star-Ratings</li> </ul> <p>In 2015, the Centers for Medicare and Medicaid Services (CMS) introduced star ratings on Hospital Compare, the Agency’s public information website, to make it easier for consumers to choose a hospital and understand the quality of care that hospitals deliver. However, the methodology currently used to calculate the star ratings has led to inconsistencies and made it difficult for hospitals to predict their score. To reevaluate the Overall Hospital Quality Star Rating on the Hospital Compare website, CMS contracted with the Center for Outcomes Research and Evaluation (CORE). CORE seeks public input on their proposed methodology enhancements.</p> <p>We commend CMS’ resolve to improve the usability, accessibility and interpretability of Hospital Compare for patients and consumers. While we support CMS refining the Overall Hospital Quality Star Rating, we have some general concerns and suggestions surrounding CMS’ proposals that were included in the public input request. Our comments can be found below.</p> <p>AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like additional information, please contact Carlyle Walton, President of AHPA, at Carlyle.Walton@AdventHealth.com or Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AdventHealth.com.</p> | Carlyle Walton, FACHE, President; Adventist Health Policy Association | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System     | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>We write to detail our concerns with CMS’s Overall Hospital Quality Star Ratings and the proposals under consideration. We believe the stars ratings system should be immediately suspended and removed from Hospital Compare until a more meaningful methodology can be developed and validated, addressing the sundry issues detailed below. We are happy to lend expertise to this process should that be helpful and desired.</p> <p>In conclusion, we strongly urge CMS to suspend and remove the Overall Hospital Quality Stars Ratings system from Hospital Compare. Moving forward, we urge CMS:</p> <ul style="list-style-type: none"> <li>- To consider user-customization that takes into account what matters to patients (care for a specific condition or procedure, location, and insurance) and develop a methodology based on specific literature-based performance thresholds;</li> <li>- To abandon the use of the LVM, specifically for the safety domain;</li> <li>- To emphasize the importance of current, on-the-ground quality, and dismiss proposals that undermine this;</li> <li>- To test the robustness of any modelling decision; arbitrary methodological decisions should not drive results more than underlying quality;</li> <li>- To avoid clustering techniques where some “cutoff” matters significantly for what is reported.</li> </ul> | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                       | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>As one of the nation’s largest faith-based, nonprofit health care systems, Texas Health Resources (Texas Health) provides more than 350 points of access throughout North Texas, including 29 hospitals (acute-care, short-stay, behavioral health, rehabilitation and transitional care) and more than 100 outpatient facilities, satellite emergency rooms, surgery centers, behavioral health facilities, fitness centers and imaging centers. The system also includes a large physician group, home health, preventive and well-being services as well as more than 250 clinics and physician offices to provide the full continuum of care for all stages of life. Texas Health appreciates the opportunity to provide input on potential future changes to the Centers for Medicare and Medicaid Services (CMS) hospital overall star ratings system.</p>  | Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources   | <a href="mailto:joelballew@texashhealth.org">joelballew@texashhealth.org</a> | Healthcare System      | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>As longstanding supporters of transparency, Texas Health believes that patients, families and communities should have valid, clear and meaningful quality information to help them make important health care decisions. That is why we urge CMS to address the substantial flaws in the star ratings methodology since the ratings inception in 2016. We continue to be concerned that one of CMS’ laudable goals with star ratings—to give a meaningful, simplified view of hospital quality to consumers—is being compromised by a methodology that can lead to inaccurate, misleading comparisons of quality performance.</p> <p>Texas Health appreciates CMS’ ongoing efforts to solicit stakeholder feedback on how to improve the ratings approach. The roughly one dozen potential changes to the star ratings methodology outlined in the request for comment attempt to address several important issues with star ratings and merit serious consideration. However, we believe that only three of the proposals should be pursued further at this time: 1) empirical criteria for measure groups; 2) peer grouping star ratings using socio-economic factors (e.g., income, age, education, employment, uninsured and housing) among similar hospitals; and, 3) using an “explicit” scoring approach. The remaining proposals either fail to address important shortcomings with star ratings, or simply do not have enough information for us to judge their impact.</p> <p>Texas Health also urges CMS to consider other steps to improve star ratings that are not addressed in the draft report. We believe it is important that these steps be taken prior to considering implementation of any other changes to the star ratings. Specifically, CMS should:</p> <ul style="list-style-type: none"> <li>• Engage a small group of experts on latent variable models (LVM) to ensure its calculation approach is executed correctly.</li> </ul> <p>Develop an alternative approach to star ratings in which, instead of an overall rating, hospitals receive ratings on specific clinical conditions or topic areas. Lastly, Texas Health continues to urge CMS to remove the existing star ratings from Hospital Compare while its important work of improving the methodology continues. We appreciate the desire for the ratings to reflect the most current quality data. Yet CMS’ public comment underscores the many problems with the current methodology. Unless and until the ratings methodology is improved, it will be difficult for hospitals and the public to have confidence that star ratings portray hospital performance accurately.</p> | Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources | <a href="mailto:joelballew@texashalth.org">joelballew@texashalth.org</a> | Healthcare System      | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | In closing, Texas Health Resources appreciates the opportunity to share our comments on the proposed rule. We look forward to continuing to work with CMS to ensure star ratings achieve the goals of meaningfulness, accuracy, and transparency that we and all stakeholders share. If we can provide you or your staff with additional information, please do not hesitate to contact Joel Ballew, Vice President, Government and Community Affairs, Texas Health Resources at JoelBallew@texashealth.org, or by phone at 682-236-6794.   | Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources | <a href="mailto:joelballew@texashealth.org">joelballew@texashealth.org</a> | Healthcare System     | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>Thank you for the opportunity to provide feedback on the CMS Hospital Star Ratings on Hospital Compare. We at Hennepin Healthcare fully support the idea of transparency and sharing of meaningful hospital quality information with patients and their families. We also support the idea that this information can provide additional emphasis for individual health systems such as Hennepin Healthcare to improve the value of care that we provide to Medicare patients. Having said this, we have significant concerns with the current methodology used for Hospital Star Ratings, and we appreciate the opportunity to comment further.</p> <p>Hennepin Healthcare supports the viewpoints contained in the Public Input Requests from both the American Hospital Association (AHA) and America's Essential Hospitals (AEH). In addition to the input from AHA and AEH, we would like to provide additional comments in response to your request.</p> <p>Hennepin Healthcare is an integrated system of care that includes HCMC, a nationally recognized Level I Adult Trauma Center and Level I Pediatric Trauma Center and acute care hospital, as well as a clinic system with primary care clinics located in Minneapolis and across Hennepin County. The comprehensive healthcare system includes a 473-bed academic medical center, a large outpatient Clinic &amp; Specialty Center, and a network of clinics in downtown Minneapolis and surrounding neighborhoods. The system is operated by Hennepin Healthcare System, Inc., a subsidiary corporation of Hennepin County.</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare                               | <a href="mailto:Daniel.hoody@hennepin.org">Daniel.hoody@hennepin.org</a>   | Healthcare System     | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <p>Hennepin Healthcare is the largest safety-net system in Minnesota and serves one of the largest Medicaid populations in the nation. Hennepin Healthcare is an integrated system of care, an innovator and leader in delivery reforms and a statewide resource with medical residency training programs the state's poison control center and the largest burn center in the state, emergency and trauma services for both pediatric and adult level Itraumas, psychiatric crisis services, and addiction medicine. Hennepin Healthcare is dedicated to improving the health of our patients, many of whom are socially and medically complex. Our patients are more likely to live in deep poverty, experience homelessness, and have serious mental illnesses and substance use disorders.</p> <p>We at Hennepin Healthcare fully support the idea of publicly reported quality outcomes and their ability to improve the value of healthcare provided to Medicare beneficiaries. In theory, it is indeed logical that patients will make better choices when having access to the information that can guide them to the health system most likely to provide them with the outcome they desire. It is also logical that health systems will strive to improve if they are not a top performer in outcome measures that patients are using to drive choice. Transparent public reporting of accurate and meaningful quality outcomes should in theory decrease the information asymmetry of the health economy and allow patients to become more engaged in their own care, while at the same time improving the value of care provided to patients. Theoretical benefits do not always carry through in real-world applications, however, and with the CMS star ratings there are numerous concerns that we have related to the value that the star ratings are providing.</p> <p>The public input provided by both AHA and AEH highlights the concerns that we have about the current system and the proposed changes. In particular, we would like to highlight our agreement with AEH on their following input:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• CMS should only include reliable and valid measures in the calculation of star ratings, and ensure measure grouping and group weights are balanced and reflect areas of importance for patients.</li> </ul> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hcmn.org">Daniel.hoody@hcmn.org</a> | Healthcare System      | Please refer to the Summary Report |

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| 3/29/2019   | Overall Project & Methodology | <ul style="list-style-type: none"> <li>• CMS should re-examine the underlying methodology of the star ratings to improve their reliability, predictability, and accuracy.</li> <li>• CMS should take strategic steps to ensure confidence, by all stakeholders, in the star ratings program and the information it is intended to provide.</li> </ul> <p>In addition, we would like to highlight our agreement with AHA on their following input:</p> <ul style="list-style-type: none"> <li>• Of the CMS proposals for change, only three should be pursued further at this time: empirical criteria for measures groups, peer grouping star ratings among similar hospitals, and using an explicit scoring approach.</li> <li>• The "must have" elements for the star ratings should be as follows: usefulness to customers, accuracy, stability, a "line of sight" from star ratings to performance on underlying measures, a balanced assessment, and accounting for potential biases.</li> <li>• A rating system based upon specific clinical conditions in of one overall rating should be explored.</li> </ul> <p>In conclusion, despite our critiques of the current star ratings, we fully support the efforts that CMS has put forth towards increasing the value of the healthcare provided to Medicare beneficiaries through the publication of meaningful hospital performance data to patients. Despite the methodologic flaws of the star ratings, our individual hospital star rating highlights the need for us to improve both the rate and sustainability of clinical improvement efforts, and we take this seriously. We look forward to improvements in the star ratings methodology that better inform us of our gaps in clinical care outcomes and allow us to better strategize about how to improve our overall clinical performance.</p> <p>Likewise, we look forward to improvements in the star rating methodology that better inform patients in the important life decisions related to their health and wellbeing. We thank CMS for their active solicitation of feedback and ongoing efforts to improve the star ratings.</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hcm.org">Daniel.hoody@hcm.org</a> | Healthcare System     | Please refer to the Summary Report |

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| 3/29/19     | Overall Project & Methodology | <p>The National Organization of State Offices of Rural Health (NOSORH) is a nonprofit membership association supporting State Offices of Rural Health (SORHs) throughout the nation. All 50 states have a SORH. These offices vary in size, scope, organization, and in services and resources they provide. Most are organized within state health departments, while some are in universities or not-for-profit organizations. SORHs are Federally-funded to assist to Critical Access Hospitals (CAHs) in their states under the Medicare Rural Hospital Flexibility Program. In addition, SORHs administer, on behalf of the Federal Government, the Small Rural Hospital Improvement Program, designed to improved operational quality in smaller, non-CAH rural hospitals. SORHs are in a unique position to monitor the operations of CAHs and small rural hospitals and can deliver appropriate assistance to these facilities.</p> <p>NOSORH provides support to SORHs, including information, training and technical services. As part of this support, NOSORH performs analyses of rural hospital and CAH performance data. The findings of these analyses are provided to SORHS as state-specific hospital profiles. These profiles are used by SORHs in the development of their state-specific hospital quality improvement efforts.</p> <p>NOSORH appreciates the opportunity to provide comment to CMS on its Hospital Star Rating Program. NOSORH hopes that these comments are useful and stands ready to work with CMS on efforts to make the rating program more relevant to rural hospitals and CAHs.</p> | Teryl Eisinger, CEO, National Organization of State Offices of Rural Health                                    | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |
| 3/29/2019   | Overall Project & Methodology | <p>On behalf of the 140 hospitals that make up the acute care membership of Greater New York Hospital Association (GNYHA), thank you for the opportunity to provide comments and recommendations on the Overall Hospital Quality Star Ratings. While GNYHA supports the Centers for Medicare &amp; Medicaid Services' (CMS) goals in developing the hospital star ratings, we remain concerned about the ratings' validity and usefulness to consumers. Therefore, we greatly appreciate the continued efforts of CMS and the Yale School of Medicine Center for Outcomes Research &amp; Evaluation on the star ratings and their commitment to refine and improve the methodology.</p>  | Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a>     | Hospital Association     | Please refer to the Summary Report |



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| 3/29/2019   | Overall Project & Methodology     | <p>Our detailed comments on each topic are attached, but our key recommendations are as follows:</p> <ul style="list-style-type: none"> <li>• Suspend public release of the star ratings until their validity and reliability are improved</li> <li>• Convene a panel of experts on structural equation/latent variable models to review and strengthen the rigor of the star ratings methodology</li> <li>• Release the complete research database and SAS pack and provide another opportunity for stakeholder comment before finalizing methodological changes</li> </ul> <p>Provide star ratings for each measure group in addition to the overall hospital star rating</p>  | Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a>                           | Hospital Association                            | Please refer to the Summary Report |
| 3/26/2019   | February 2019 Methodology Updates | <p>WHA is disappointed that CMS chose to refresh the star ratings data after making very few of the proposed changes to the methodology suggested by stakeholders in the 2017 request for public input. Despite the removal of measures with a statistically significant loading factors, and the replacement of measure denominators for “predicted” healthcare associated infection rates, the continued complexity of the star rating methodology and statistical process makes replication of the results and action by hospitals to improve their scores daunting. We acknowledge that the aged star ratings frozen on CMS’ Hospital Compare website were less than ideal. CMS could have chosen to remove the ratings from the website, acknowledging that revisions to the program were underway.</p> | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association  | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                         | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | February 2019 Methodology Updates | <p>We recommend a deep dive into HAI data using additional sources to understand instability. Addition of volume-based denominators (Device days, number of procedures and total patient days should help.)</p>  | Dale N. Schumacher, MD, MPH, President, Rockburn Institute   | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |



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| 3/29/2019   | February 2019 Methodology Updates | <p><b>Understanding the Effect of the February 2019 Changes</b></p> <p>In November 2018, CMS announced two methodology updates; to remove measures with statistically significant negative-loading coefficients and to change the weighting of hospital-associated infection measures in the safety-of-care group. However, CMS’ two new methodology updates, which were reported in the February 2019 release, do not address concerns voiced by Vizient, as well as other stakeholders, particularly regarding the latent variable modeling approach. While the intent may have been to address methodology issues, CMS has instead inadvertently potentially introduced even more instability into the Hospital Star Rating system. Vizient is extremely concerned that the flawed methodology currently used to determine the Ratings that are posted on the Hospital Compare website are both inaccurate and misleading to patients seeking care.</p> <p><b>Latent Variable Modeling Affects Loading Coefficients to Create Misleading Results</b></p> <p>CMS has stated that latent variable modeling provides an objective way to assign measured importance or weights for each of the seven performance areas in the ratings. However, after analyzing the February 2019 publically available CMS Hospital Star Rating data (the most current available) which included two methodological improvements, Vizient continued to identify significant opportunities in the CMS latent variable modeling choices indicating modeling selection bias, producing unreliable loading coefficients and ultimately potentially misleading results.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | February 2019 Methodology Updates | <p>Change 1: Removing Measures with Statistically Significant Negative Loading Coefficients</p> <p>While the July 2018 Star Ratings were never officially released, hospitals with better performance in the Healthcare-Associated Infection (HAI) measure were being penalized. This counter-intuitive measure evaluation was driven by applying latent variable modeling which calculated negative measure weighting, lowering a hospitals' score for better performance. To address this concern, CMS committed to removing statistically significant measures which penalized hospitals for better performance, otherwise known as negative measure loading coefficients.</p> <p>For the February 2019 Star Rating release, no measures met the statistically significant criteria as shown in Figure 1, but one measure OP-32: Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy measure reports a negative-loading coefficient of -0.01 <a href="#">[Table 6]</a>. While this measure has marginal impact on the overall hospital score, the presence of this non-significant negative loading is symptomatic of a sub-optimal modeling approach. Vizient strongly supports the movement to value-based care, and does not believe that hospitals should be penalized by any amount – small or large – for providing better care.</p> <p>Change 2: Healthcare-Associated Infection (HAI) measures</p> <p>CMS' second methodological shift was to use device days, number of procedures, and patient days instead of predicted infections to weight measure scoring for the HAI measures. CMS stated that the denominators help stabilize the measure weighting within the group and reduces the sensitivity of the methodology to an individual measure change. This methodology update was as a result of the significant loading coefficient swings in the Safety group for the Patient Safety Composite Measures (PSI-90) and the Total Hip &amp; Knee Complications (THK) between the July 2018 (not released) and the December 2017 (released) Star Ratings. Vizient found this to be of considerable concern, as no prior release of the CMS Star Ratings have had the significant shifts we saw in July 2018 as shown below in <a href="#">[Table 7]</a>.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/2019   | February 2019 Methodology Updates | <p>The February Star Rating Safety group loading coefficients appear to be more aligned with previous releases. To better understand the impact of using patient days and device days instead of predicted HAIs, Vizient simulated the impact by analyzing the December 2017 Star Rating publically available data from QualityNet and Hospital Compare, substituting patient days and device days for predicted infection in a latent variable modeling algorithm. The results indicated nearly zero changes in Hospital Star Ratings – as only one hospital’s rating moved from 3 to 4 stars <a href="#">[Table 8]</a>.</p> <p>Vizient compared the impact on the Safety group loading coefficients from our simulations with the published December 2017 coefficients, and found marginal differences as shown in <a href="#">[Table 9]</a>.</p> <p>The CMS February methodology document does not reference additional methodological changes that account for the sizable shift in measure loading between July 2018 and February 2019 Star Ratings as shown in Table 2. Coupled with the Vizient simulated results indicating marginal Star Rating changes due to the methodology updates, the February results are disconcerting. We believe the dramatic differences found are due to CMS’ continued use of latent variable modeling.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.   | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |
| 3/29/2019   | February 2019 Methodology Updates | This update demonstrates the lack of validity of the LVM. Negative factor loadings on variables that are supposed to measure affirmative quality indicate that there is indeed not a single latent factor (the assumption underlying the LVM). Rather than simply removing these measures, the negative factor loadings should have spurred inquiry about whether the choice of LVM was appropriate at all. The choice should not be between a post-hoc fix to the LVM or a retention of an aspect that lacks face validity—it should instead prompt a search for a model that does not present such a tradeoff.  | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                           | Medical University                         | Please refer to the Summary Report |
| 3/6/2019    | Measure Grouping                  | 3. Actively following measure groupings for consistency in how much each measure influences the measure group score over time.  | Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare   | <a href="mailto:RHyke@stanfordhealthcare.org">RHyke@stanfordhealthcare.org</a>   | Individual                                 | Please refer to the Summary Report |

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| 3/14/2019   | Measure Grouping       | <p>-We would like to use a three-step approach (clinical coherence, confirmatory factor analysis, and ongoing monitoring) to define measure groups. Is this approach reasonable?</p> <p>In general, this approach is reasonable, and we support its continued use. We would suggest, though, that the assumption of a single underlying factor in the measure groups be abandoned as both unnecessary and incorrect for at least some groups. As noted in the Request document, there seem to be more than one underlying factor in the Safety group, and it may turn out that more than one factor is also present in other groups if even minor changes to measure definition or risk adjustment are made in the future. The assumption of one underlying factor has led to clear problems with measure loading or weighting in the Safety category, and these problems can be easily eliminated if the starting assumption of one underlying factor is abandoned. A group of measures can be scored together in a meaningful and interpretable way even if there are two or more underlying factors present.</p> <p>-Should CMS use the balance and consistency of loadings as a factor in evaluating grouping?</p> <p>Yes - balance and consistency of loadings should be a factor in evaluating groupings.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/14/2019   | Measure Grouping       | <ul style="list-style-type: none"> <li>Is the current grouping or one of the potential alternative groupings of the Safety of Care measures most suitable for the Overall Hospital Quality Star Rating based on previously mentioned criteria?</li> </ul> <p>The alternative grouping of measures into Surgical and Medical safety groups does appear to have some advantage over the current grouping, but it is not clear that the labels are accurate or informative - surgical patients may have central lines and catheters inserted and be vulnerable to C-diff infections.</p> <p>The resulting changes in variable loadings (Tables 5-8), though, indicate that just re-grouping the measures, under either of the two options presented {keep PSI-90 or move to the PSI-90 component measures) does not solve the problem of highly uneven weighting of measures within the group(s). Any of the solutions illustrated here leaves one measure with a highly dominant effect on the category score - the options just change which measure it is, and how totally dominant it is. It would seem better (as noted in responses below) to switch to a pre-determined weighting system built on the basis of two concepts - more even weighting of individual measures, and differences in weighting driven by clinical significance (e.g., QALYs gained or lost as a result of performance on the measure) - rather than by results of complex statistical analysis linked to both the LVM model and the concept of precision.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/21/2019   | Measure Grouping       | <ul style="list-style-type: none"> <li>We would like to use a three-step approach (clinical coherence, confirmatory factor analysis, and ongoing monitoring) to define measure groups. Is this approach reasonable?</li> </ul> <p>Yes. Confirmatory factor analysis is very important to ensure that one dominant factor is underlying the quality measure performance.</p> <ul style="list-style-type: none"> <li>Should CMS use the balance and consistency of loadings as a factor in evaluating grouping?</li> </ul> <p>Yes. Loadings are the most difficult part of the star rating calculations to explain. Changes in loadings over time and the impact on the star rating creates challenges in being able to analyze performance and identify opportunities for improvement.</p> <ul style="list-style-type: none"> <li>Is the current grouping or one of the potential alternative groupings of the Safety of Care measures most suitable for the Overall Hospital Quality Star Rating based on previously mentioned criteria?</li> </ul> <p>The current grouping is more suitable than the alternatives. The PSI-90 measure is in hospital pay for performance programs. The PSI measures should be used consistently across these programs and the star rating. Either all programs should continue to use the composite or all programs should split the measures apart. Either way the individual measures do not end up being equally weighted in regards to impact on the final score.</p> | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health  | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System         | Please refer to the Summary Report |
| 3/22/2019   | Measure Grouping       | <p>WHA fully supports including measures of care that reflect and align to CMS' priorities aimed at improving the effectiveness of care that leads to positive patient outcomes. WHA recognizes that the PSI-90 composite measure and the Hip/Knee Complication rate measure factor heavily into the safety of care measure group. However, the option of un-bundling PSI-90 to include only select component measures will prove challenging because of the scarce quantity of data and high performance levels of hospitals in several of the metrics. WHA agrees with the Technical Expert Panel (TEP) in not supporting either of the re-grouping options.</p>   | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a>                                   | Hospital              | Please refer to the Summary Report |

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| 3/22/19     | Measure Grouping       | <p>We agree that grouping measures into domains is a reasonable way to aggregate data and agree with clinical criteria as a grouping method. Thus, the groupings for mortality, safety, readmission and patient satisfaction are reasonable for a quality and patient perspective. We are concerned with how items have been selected for specific domains and how the model has been validated for each domain. In particular, we have concerns about the application of latent variable modeling (LVM) as the statistical method of creating domain scores. The recent results from this model have produced grossly fluctuating coefficients. For example, the coefficient for PSI-90 changes from 0.17 to 0.90 in the space of 6 months (July 2018 suppressed, to Feb 2019). The July 2018 modeling also produced several negative coefficients. These negative coefficients mean that better performance on the metric worsened domain performance and worse performance improved domain score. This defeats the purpose of the ratings. Better performers should receive a better score. A metric important enough to merit inclusion should positively influence domain performance. It is unclear to us how and why the model produced this or why any metric with negative loading would be retained in the model, regardless of statistical significance.</p> <p>We are also concerned that some domains seem to have little contribution from most of the measures. For example, PSI-90 current weight dwarfs all other metrics in the safety domain. We would suggest that other measures do contribute to an overall understanding of safety, and the methodology employed should produce a score that provides a fuller picture of multiple safety criteria.</p> <p>The LVM assumes domain variables correlate with each other as manifestations of a latent factor. We are concerned this underlying assumption is incorrect, and may invalidate the practical impact of the results, in several domains. For example, the effectiveness of care domain includes three metrics we suspect are not correlated: early elective delivery, aspirin at arrival and external beam radiotherapy for bone metastasis. Even if they are slightly correlated, it would be unclear to us what this domain score would truly represent.</p> | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a> | Hospital              | Please refer to the Summary Report |

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| 3/22/2019   | Measure Grouping       | If CMS continues to choose LVM as the method of scoring domains, then this would require a transparent reanalysis of the variables in each domain for correlation and validity. As such, we are supportive of the approach outlined in section 4.1.2 involving clinical grouping, confirmatory factor analysis, and ongoing active monitoring.  | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital                       | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a> | Hospital              | Please refer to the Summary Report |
| 3/26/2019   | Measure Grouping       | <p>• <b>Measure Grouping and Re-grouping:</b> WHA fully supports including measures of care that reflect and align to CMS’ priorities aimed at improving the effectiveness of care that leads to positive patient outcomes. WHA recognizes that the PSI-90 composite measure and the Hip/Knee Complication rate measure factor heavily into the safety of care measure group. However, the option of un-bundling PSI-90 to include only select component measures will prove challenging because of the quantity of data and performance levels of hospitals in several of the metrics. WHA agrees with the Technical Expert Panel (TEP) in not supporting either of the re-grouping options.</p>   | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association   | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>       | Hospital Association  | Please refer to the Summary Report |
| 3/27/2019   | Measure Grouping       | <p>New criteria for creating and maintaining measure groups. The AHA supports CMS’s 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.</p> <p>We believe the confirmatory factor analysis would be especially helpful and important to implement. The fundamental premise of the LVM approach used in star ratings is that one can summarize the performance of the measures on an aspect of care (e.g., safety, mortality) into a single score that accounts for both actual performance and unobserved (or latent) performance. One way to test whether that assumption holds true is to use a confirmatory analysis to determine the extent of variation that is explained by the model. Performing this analysis on an ongoing basis would provide a stronger empirical basis for the measure groups, and identify groups that may need to be revised in the future.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>       | Hospital Association  | Please refer to the Summary Report |



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| 3/27/2019   | Measure Grouping       | <p>First, we strongly oppose any approach to scoring hospitals on individual components of the PSI composite measure in the safety measure group. In fact, the AHA continues to urge CMS to transition PSI measures out of all of its measurement programs. The AHA has long been concerned by the significant limitations of PSIs as a quality measure. PSIs use hospital claims data to identify patients who have potentially experienced a safety event. However, claims data cannot and do not fully reflect the details of a patient’s history, course of care and clinical risk factors. As a result, the rates derived from the measures are highly inexact. PSI data may assist hospitals in identifying patients whose particular cases merit deeper investigation with the benefit of the full medical record. But, the measures are poorly suited to drawing meaningful conclusions about hospital performance on safety issues.</p> <p>In other words, PSIs may help hospitals determine what “haystack” to look in for potential safety issues. But the ability of the measure to consistently and accurately identify the “needle” (i.e., the safety event) is far too limited for use in public reporting and pay-for-performance applications. It is not surprising that a 2012 CMS commissioned study showed that many of the individual components of PSI-90 have unacceptably low levels of reliability when applied to Medicare claims data.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>     | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Measure Grouping       | <p>MHA appreciates the revised criteria, three-step approach and evaluation of loading balance and consistency as both reasonable and, frankly, necessary for any measurement approach leveraging latent variable methods. We also appreciate the frank and transparent exposition of serious problems with the current handling of the Safety of Care measure group. Taken together, the proposed updates would help mitigate a number of the serious concerns that we and our peers have raised in previous comments about the apparent extreme imbalance among loadings for some measurement groups and potential single dimension underlying Star Ratings measure groups. While in the longer-term, we would advocate for complete rethinking to leverage methodologically simpler, more transparent methods for calculating Overall Star Ratings; these updates represent a substantive improvement.</p>   | Herb B. Kuhn, President, CEO, Missouri Hospital Association   | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Measure Grouping       | MHA appreciates the transparency and completeness of the exposition presented in this section as supporting the application of the criteria presented in the previous section to entertain alternative groupings for the Safety of Care measures, which clearly do not represent a single dimension of variation. We do not, however, find either presented dimension to be an effective alternative to the current approach, in part because confirmatory factor criteria are not present, and in part because we do not think the presented application of the criteria fully consider the dimensionality of this group of measures. In a study recently published in the American Journal of Medical Quality, Hu et al show factor analysis findings that suggest four distinct factors appear underlying the Safety of Care measure group. While this finding is by no means presented as definitive, it illustrates that perhaps the alternatives presented may not represent a definitive application of the criteria and three-step approach outlined in the prior section. Put simply, we do not feel that either proposed alternative effectively summarizes the variation among the candidate items to an extent that ensures that the purposes of the Overall Star Ratings are met. MHA suggests that measure developers leverage the approach to consider a broader array of grouping alternatives to find an approach that suits the dimensionality of the Safety of Care set and meets proposed criteria for clinically and empirically sound measurement. | Herb B. Kuhn,<br>President, CEO,<br>Missouri Hospital<br>Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital<br>Association | Please refer to the<br>Summary Report |

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| 3/28/2019   | Measure Grouping       | <ul style="list-style-type: none"> <li>Measure Groupings: CMS should undertake further analysis on how to improve measure groupings before implementing any changes.</li> <li>Regrouping Measures: The AAMC does not support the proposed alternative grouping for the Safety of Care group or the use of PSI components in lieu of the PSI-90 composite measure. CMS should consider simpler alternative approaches before implementing any regrouping of measures.</li> </ul> <p>Measure Grouping</p> <p>CMS seeks feedback on using an explicit three-step approach to define measure groups that might be reasonable to ensure that measure groups are both clinically and empirically rational. CMS is proposing a new approach to measure grouping based upon three criteria: initial clinical grouping, confirmatory factor analysis, and ongoing active monitoring. The reasoning behind this proposal is that in part the Agency has begun to retire measures from the Inpatient Quality Reporting Program and other hospital reporting and performance programs as part of its broader Meaningful Measures Framework, and recognizes that changes to the measures reported on Hospital Compare could have an impact on the current measures groups utilized in the Star Ratings methodology. The AAMC believes that the three-step approach to define measure groups is reasonable, but CMS should undertake further analysis on how to improve measure groupings before implementing any changes. Our concerns are discussed in further detail in the following section in regard to the impact such an approach would have on the Safety of Care measure group.</p> <p>into medical and surgical groupings, since many of the components are not exclusively medical or surgical. For example, pressure ulcers (designated as medical) could result from the required rest following a complicated surgery or the rate of postoperative respiratory failure (designated as surgical) is influenced more by a patient's co-morbidities than the surgery itself.</p> | Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Measure Grouping       | <p>Second, breaking PSI-90 into components may decrease the reliability of the measures by assigning scores to very rare events. We encourage CMS to provide information about the statistical significance of the measured rates of individual PSI measures at the hospital level. Further, the denominators may vary drastically across hospitals and could exacerbate the biases seen in the PSI- 90 composite. Even at the national level, individual components saw huge swings in weight across time. In Table 8CMS showed that not only did four components change by more than 0.20 across periods, but they also caused changes in other measures in the same group, such as hip/knee complications, which changed by over 0.50 across periods. It is noteworthy that these changes occurred despite no updates to the hip/knee complications measure itself, such as between July 2017 and December 2017. Thus, we are concerned that breaking down PSI-90 into individual components could further destabilize the Safety of Care group. The AAMC does not support the use of the PSI components in lieu of the PSI-90 composite measure and would encourage caution in using measures that bring reliability into question. The AAMC continues to believe that the PSI-90 composite measure should be removed from the Star Ratings.</p> <p>An alternative CMS would be to implement a simpler approach that focuses on consistent and balanced measure loadings. Such a model would increase interpretability and add needed balance across the measures of a unified Safety of Care measure group, and remove the need to split the group into two. The AAMC urges CMS to consider simpler alternative approaches before implementing any regrouping of measures.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer   | <a href="mailto:galee@aamc.org">galee@aamc.org</a>       | Professional Association | Please refer to the Summary Report |
| 3/28/2019   | Measure Grouping       | Data grouping should also be consistent and not reported in homogenous grouping methods.  | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System            | Please refer to the Summary Report |

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| 3/28/2019   | Measure Grouping       | Measure Grouping: If CMS chooses to keep the current grouping approach, we would support the proposal to break the Safety of Care domain into medical and surgical subparts, with the PSI-90 composite broken into the individual patient safety indicators (PSIs). We believe that medical/surgical distinction is important to patients and the quality improvement strategies that hospitals employ in each of those areas can vary.   | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a>       | Health Organization    | Please refer to the Summary Report |
| 3/28/2019   | Measure Grouping       | <p>The following are our comments on the methodology under re-evaluation for the Overall Hospital Quality Star Rating. If there are any questions, please contact:</p> <p><b>Covenant Health</b><br/> Mark Browne, MD, MMM, CPE, FACPE<br/> Senior Vice President / Chief Medical Officer<br/> Office: (865) 531-4326<br/> Email: <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a></p> <p><b>CMS Star Rating Feedback</b><br/> <b>4.1 Measure Grouping</b><br/> <b>Questions for the Public:</b><br/> We would like to use a three-step approach (clinical coherence, confirmatory factor analysis, and ongoing monitoring) to define measure groups. Is this approach reasonable? <b>Yes, I agree with the more explicit approach which includes both a clinical rationale and empirical criteria for checking for dominant factor. In Criterion 2, the re-assessment of the Factor analysis with every subsequent Star Rating publication to ensure that a dominant underlying quality measure exist is important, especially with changes in measures on Hospital compare. Also, the use of the Scree plot is important for determining dominance. The plot should be consistent or similar across all measure groups indicating one strong factor. If this is not present, the measure group should be re-evaluated or not included in the Star rating.</b></p> | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health  | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/28/2019   | Measure Grouping       | <p>Should CMS use the balance and consistency of loadings as a factor in evaluating grouping? <b>Yes, loadings should be balanced within periods and consistent between periods for predictability. When loadings change from period to period, it is impossible to use this information for performance improvement purposes. Choosing a consistent and explicit model that is easy to understand and replicate is of paramount importance.</b></p> <p><b>4.2 Regrouping of Measures</b></p> <p><b>Question for the Public:</b></p> <p>Is the current grouping or one of the potential alternative groupings of the Safety of Care measures most suitable for the Overall Hospital Quality Star Rating based on previously mentioned criteria? <b>Not supportive of the re-grouping option (Medical Safety/Surgical Safety) since the goal of achieving more balanced loadings was not met. However, the idea of using the individual measures instead of the PSI 90 composite is more appealing. All measures should be evaluated and those measures not influencing the measure group score over time should be removed. Consideration should be given to moving away from the PSI metric all together. Many in the healthcare industry continue to voice concerns overly weighting certain metrics here that unduly influence the ultimate star rating.</b></p> | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System         | Please refer to the Summary Report |

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| 3/28/19     | Measure Grouping       | <p>RUMC Response:</p> <p>1. We agree with keeping clinical domains – we would be interested in there being input about which clinical domains are used. A broader distribution than the clinical syndromes currently used – ie. Acute MI, COPD, CHF, Stroke etc. – would be useful and help to make the ratings more universally meaningful. Obviously validation of these new domains would be required.</p> <p>2. If latent variable modeling is kept, testing to see if the incorporation or removal of a measure changes the distribution of weight or dominance by any one measure is recommended. The current example is the Safety Domain. As that domain was constructed, design consideration should have been made that the six HAI measures were being dominated by PSI-90 and THA-TKA Complications. The result, in Feb 2019 release, is PSI-90 is almost perfectly correlated with the safety domain score, where C.Diff (HAI-6) has no statistical correlation with the safety domain score. See the following <a href="#">[Figure 3]</a> <a href="#">[Figure 4]</a>.</p> <p>Maybe this should have warranted moving these six HAI measures to a new domain, such as “Safety-Infections” and rename PSI-90 and THA/TKA Complications to “Safety-Surgical”.</p> | <p>Dr. Omar Lateef<br/>Stuart Levin, MD<br/>Presidential Professor of Rush University<br/>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br/>Rush University Medical Center<br/>Chicago, Illinois<br/>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine<br/>Thomas A. Webb, MBA<br/>Manager, Quality Improvement; Rush University Medical Center</p> | <p><a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a></p> | Medical University    | Please refer to the Summary Report |

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| 3/28/19     | Measure Grouping       | The majority of measures included in the Mortality, Readmission, Safety, Efficient Imaging and Effectiveness -Process domains are measures based on narrowly defined cohorts. Especially at small and even true at many large hospitals, the cohorts of patients in AMI, PN, or HF can be very small. This has led to having very long measurement periods (three years) to create meaningful denominators. We recommend removing these narrowly defined measures from the overall rating and move to measure that more broadly measure the quality of care at hospitals. The best example is the HWR measure in the Readmission domain. This measure has a large enough denominator to allow for only one year of aggregation and the latent variable model clearly prefers that measure. Why keep all the other measures in the Readmission domain when HWR is dominant? They are actually redundant as those cohorts are already included in the HWR measure. The creation of a risk adjusted hospital-wide 30-day mortality measure to be used as the mortality domain would then be a great next step. With these larger measures, less correction for precision will be necessary because hospital's individual performance will be less prone to random variation. | Dr. Omar Lateef<br>Stuart Levin, MD<br>Presidential Professor of Rush University<br>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br>Rush University Medical Center<br>Chicago, Illinois<br>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine<br>Thomas A. Webb, MBA<br>Manager, Quality Improvement; Rush University Medical Center | <a href="mailto:Thomas.A.Webb@rush.edu">Thomas A Webb@rush.edu</a>                         | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | <b>2. Measure Groupings, Regrouping, and Precision:</b> CMS should undertake further analysis on how to improve measure groupings before implementing any changes   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health   | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System          | Please refer to the Summary Report |



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| 3/29/19     | Measure Grouping       | <b>2. Measure Grouping, Re-grouping and Precision</b><br>Advocate Aurora fully supports including measures of care that reflect and align to CMS's priorities aimed at improving the effectiveness of care that leads to positive patient outcomes. We agree that CMS must reconsider how measures are grouped, since there are frequent additions and removals of reported measures and recognize that the PSI-90 composite measure and the Hip/Knee Complication rate measure factor heavily into the safety of care measure group. However, the option of un-bundling PSI-90 to include only select component measures will prove challenging because of the scarce quantity of data and high-performance levels of hospitals in several of the metrics. | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health       | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System         | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | Advocate Aurora agrees with the Technical Expert Panel (TEP) in not supporting either of the re-grouping options.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health       | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System         | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | Our feedback to potential short-term changes are as follows:<br>1. <u>Measure groupings</u> . Current groupings are based on clinical coherence, measure type, and underlying latent traits of quality and are weighted using the latent variable model (LVM) methodology. (See below for comments on the LVM methodology.) Based on the current CMS priority to reduce administrative burden and focus on a reduced set of measures that are deemed more meaningful, it is possible that in future star ratings there will be considerably fewer measures to include in each grouping. <b>We do agree that measure groupings should retain clinical coherence and relevance to the public consumer.</b>  | Cynthia Deyling, MD,<br>MHCM, FACP, Chief<br>Quality Officer;<br>Cleveland Clinic  | <a href="mailto:deylingc@ccf.org">deylingc@ccf.org</a>                                     | Medical University    | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | To provide some clarity for consumers, HANYS urges CMS to categorize the measure groups using relatable terms, such as obstetrical outcomes, surgical outcomes and infections, rather than compiling them under one broad category, such as Safety of Care or Effectiveness of Care.  | Marie Grause, RN, JD,<br>President, Healthcare<br>Association of New<br>York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a>                                   | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>As individual measure specifications are updated or measures are added or removed from programs that post data on Hospital Compare (including measures retired as part of the Meaningful Measures initiative), CMS may need to reconsider the way that it groups measures and defines measure groups.</p> <p>HANYS supports the introduction of all three steps to evaluate the appropriateness of measure groupings over time. In particular, HANYS urges CMS to modify all domains where more than one dominant factor exists, as demonstrated by the review of statistical scree plots. As CMS states, the pattern observed for the Safety of Care domain differs from others in that the loadings remain consistent but are not well balanced; specifically, PSI-90 has a more substantial loading than other measures.</p> <p>This finding supports the need for modifications to ensure statistical accuracy for each domain. While some CMS proposals mitigate this issue (i.e., shifting to use confidence interval weighting in latent variable modeling), most of these proposals have multiple conflating factors. HANYS urges CMS to consider removal of the PSI-90 composite and/or component measures to avoid mixing claim-based quality metrics with very different, chart-abstracted measures in the safety domain.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State                     | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a>                                   | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | We are very interested in further discussions of re-grouping PSIs & infections by medical/surgical. Please let us know if additional input is desired   | Larry Mandelkehr, Executive Director, Hospital Quality and Innovation, UNC Health Care System | <a href="mailto:Larry.Mandelkehr@unchealth.unc.edu">Larry.Mandelkehr@unchealth.unc.edu</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>The three-step approach is reasonable, ensuring one factor is being measured with each grouping. Balance and consistency are equally important. Without balance, organizations may “teach to the test” and focus on the measures with higher loadings. Without consistency, public confidence in the methodology will likely wane.</p> <p>The current Safety of Care has been heavily weighted towards PSI-90 consistently, with minimal weight placed on HAI. This is misleading unless you dig deep into the methodology.</p> <p>Separating out surgical and medical makes sense to providers, but less so to consumers. Again, potentially misleading as surgical patients may just look to surgical safety, yet medical safety could significantly impact their stay and recovery.</p> <p>I’d be curious to see what the weights look like keeping all measures in same grouping, breaking out PSI-90. What are the effects (in terms of coefficients and error) of using LVM with a composite measure?</p> | Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health                                       | <a href="mailto:kathleencarrothers@gmail.com">kathleencarrothers@gmail.com</a> | Individual            | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | LVHN does not feel that making a change to the measure groups will improve the sensitivity of the Star rating. These changes will not impact the scoring unless the LVM methodology is addressed.  | Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a>           | Health system         | Please refer to the Summary Report |

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| 3/29/19     | Measure Grouping       | <p>We are supportive of CMS using the proposed three-step approach to define measure groups.</p> <p>We are also supportive of CMS using loading consistency in evaluating grouping, unless there are substantial measure changes in a group. It will help hospitals to understand rating changes based on their underlying measure performance changes. However, the options to address factors that either have inconsistent loading or have very high loading should be clearly specified in advance, if possible. We also believe that deeper investigation and explanation of high or inconsistent loading factors is warranted. For example, while PSI-90 has disproportionate weight in the Safety of Care domain, the reasons for this relatively high weighting are unclear. We would recommend continuing with the current grouping of the Safety of Care domain, though we would favor additional exploration into the reasons for the high weighting of the PSI-90. As the PSI-90 is a reasonably well validated scale, and is reportable from current data, we would not favor dropping it unless there are clear alternatives to capture safety beyond HAIs.</p> <p>The proposed regrouping does not appear to solve the issues in the current grouping based on the data presented. The current group has a lower ratio of first to second eigenvalue and the PSI-90 indicator's loading is very high, but the loadings for all measures were reasonably consistent from July 2016 to the February 2019 releases. The alternative option 1 had an even lower eigenvalue ratio for the Surgical Safety group, and PSI-90's loading was still very high. The Surgical Safety group in the alternative option 2 had a similar eigenvalue ratio with the current group, but it would introduce a strong inconsistency in loadings on several measures in the December 2017 release. Further, the separation of medical and surgical in the HAI measures is not clear from a clinical perspective. In fact, all of the "medical" HAI categories can occur equally on surgical services. Overall, it does not appear that partitioning safety into medical and surgical groups improves the reliability or consistency of the model.</p> | Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan | <a href="mailto:svijan@med.umich.edu">svijan@med.umich.edu</a> | Medical University    | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>The public input request notes that CMS is considering a three-step approach to regrouping and defining measure groups:</p> <ol style="list-style-type: none"> <li>1. Grouping measures based on clinical criteria;</li> <li>2. Using statistical tests to determine if an important latent quality trait is represented by the measures in the group; and</li> <li>3. Actively following measure groupings for consistency in how much each measure influences the measure group score over time.</li> </ol> <p>With respect to measure grouping, we support evaluation of measures within a group to determine if any have significant loading characteristics (and, if negative, if they should be removed). We note, however, that this approach is less intuitive for users and stakeholders and appears to rarely have influence on final star ratings. Finally, we agree it is important to actively monitor measure groupings over time to ensure consistency and soundness of their influence on hospital ratings.</p> | Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals | <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <p>Cedars-Sinai supports CMS' proposal to use a three-step approach, including confirmatory factor analysis, as outlined in section 4.1.2., to assure that measures within a group represent a single construct. Such an approach might be useful in addressing the issues with the Safety of Care measure group that fails the proposed criteria, as compared to the Mortality group that represents a single construct. Neither of the proposed options meet the criteria in 4.1.2, with the surgical safety grouping being especially weak. Although Option 2 achieves somewhat more balanced and consistent measure loadings, this approach ignores the harm weighting developed for the PSI-90. Hence, given these shortcomings, the confirmatory factor analysis approach proposed in 4.1.2 should be used as a guide to any future regrouping of measures.</p>  | Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center                | <a href="mailto:gail.grant@cshs.org">gail.grant@cshs.org</a>   | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>Should CMS use the balance and consistency of loadings as a factor in evaluating grouping?</p> <p>We support this.</p> <p>We agree that the measure grouping needs to be able to accommodate the future changes that are ever evolving with IQR measure and program changes. The 3-step approach seems reasonable. However, we feel that “ongoing monitoring” needs to be better defined. Does this mean the Star Rating calculation could change for every refresh? If the Star Rating is refreshed annually as proposed in section 4.4, then, there is a delicate balance between predictability for the Star Rating performance for hospitals and the flexibility for measures grouping / adaptability. If there were to be re-grouping, which the technical panels did not support, we think Option 2, using PSI components rather than the PSI-90 composite seems to be more clear from a consumer perspective. Even though 8 of the 10 PSIs are surgical-related, the two medical measures, 03-pressure injury and 08-falls, are measures that are highly visible in hospitals with improvement efforts and also with customer awareness – for this reason, it makes sense to not mask these two measures in the surgical group and have the PSI- components be broken into the surgical and medical groups.</p> | Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital                              | <a href="mailto:linnea.huinker@northmemorial.com">linnea.huinker@northmemorial.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | ZSFG strongly opposes any approach to scoring hospitals on individual components of the PSI composite measure in the safety measure group.  | Troy Williams, RN, MSN, Chief Quality Officer; Zuckerberg San Francisco General Hospital and Trauma Center | <a href="mailto:leslie.safier@sfdph.org">leslie.safier@sfdph.org</a>                   | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | Measures should be grouped appropriately. The Safety of Care measure group is sub-optimally constructed. The published proposed changes do not provide an adequate solution for this measure group. Additional consideration should be given to removing the PSI-90 and THR/TKR complication measure from this group.   | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality   | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a>                     | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>Measures should be grouped appropriately. The Safety of Care measure group is sub-optimally constructed. The published proposed changes do not provide an adequate solution for this measure group. Additional consideration should be given to removing the PSI-90 and THR/TKR complication measure from this group.</p> <p>4.1. Measure Grouping</p> <p>CMS would like to use a three-step approach (clinical coherence, confirmatory factor analysis, and ongoing monitoring) to define measure groups. Is this approach reasonable?</p> <p>The three step process described is a reasonable approach to grouping measures. The outstanding issue is that it still relies on Latent Variable Models (LVM) to determine if the measures in the group are measuring the same underlying process. Our positive view on using the described three step process is dependent on ensuring a more rigorous application of LVM.</p> <p>We believe additional factors must be evaluated when using LVM:</p> <ul style="list-style-type: none"> <li>-Stability of each LVM (defined as a group of measures) should be confirmed using a form of bootstrap analysis. Ongoing monitoring of trends of loading coefficients may provide only complimentary evidence in this respect. Additionally, it would be useful to compare estimates produced by an LVM within various samples representing relevant groups of hospitals such as teaching and non-teaching hospitals. We would expect that the parameter estimates yielded by a stable model when fitted in different subsets of hospitals should remain similar.</li> <li>-All LVMs used in the Star Ratings should be assessed using the same set of statistical tests and the results of these tests should be presented publicly in full detail. The tests should include, at a minimum, confirmatory factor analysis as well as conventional indicators of model fit - such as comparative fit index (CFI), the Tucker Lewis Index (TLI), or root-mean-square error of association (RMSEA)) and stability tests. We believe that all statistical tests should be performed consistently and all results should be shared publicly for evaluation by stakeholders.</li> </ul> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>Should CMS use the balance and consistency of loadings as a factor in evaluating grouping?</p> <p>-Yes, it is imperative that this qualitative review occur to ensure face validity of the measure loading and final grouping. Additionally, this criterion should be used to help direct if a measure should be included in a group. Including this qualitative analysis in the prior analyses might have avoided significant confusion and controversy. Incorporating it in the future will improve the consistency and reliability of the methodology.</p> <p>4.2. Regrouping of Measures</p> <p>Is the current grouping or one of the potential alternative groupings of the Safety of Care measures most suitable for the Overall Hospital Quality Star Rating based on previously mentioned criteria?</p> <p>-No. We are not supportive of either of the regrouping options presented for the Safety of Care group.</p> <p>-In order to provide a recommendation about optimal Safety of -Care measure grouping, we would need to assess full information for all considered possibilities. This full information would minimally include stability, model fit, and confirmatory factor analysis.</p> <p><input type="checkbox"/> We also believe there must be additional consideration to remove PSI-90 and/or Hip/Knee Complications from the Safety of Care group. The underlying processes around these measures are not measuring the same processes as the HAI measures.</p> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a> | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <p>-In measure groupings we suggest actively following the measure groupings to verify consistency in how much each measure influences the measure group score over time to make sure that no one measure is driving the grouping score more heavily than the other included measure</p> <p>-We suggest that the measure groupings should be based on clinical criteria</p>  | Amy Arnett, MS, RN,<br>CPHQ, CPPS<br>Quality/Infection Prevention Manager<br>Horizon Health   | <a href="mailto:aarnett@myhorizonhealth.org">aarnett@myhorizonhealth.org</a>     | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <p>In the short term, CHA:<br/>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.</p>  | Alyssa Keefe, Vice President of Federal Regulatory Affairs,<br>California Hospital Association  | <a href="mailto:nhoffman@calhospitals.org">nhoffman@calhospitals.org</a>         | Hospital Association  | Please refer to the Summary Report |



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| 3/29/2019   | Measure Grouping       | <p>Grouping Measures based on Clinical Criteria</p> <p>Measure groupings should provide the most consistent and understandable information for the consumer. Due to the ongoing retirement of measures and addition of new measures, consideration of regrouping is appropriate and we support any efforts which result in groupings that accurately and reliably reflect cohesive sets of clinical criteria. Specifically, we suggest the following measure grouping changes:</p> <ul style="list-style-type: none"> <li>a.) Adding VTE-6 and SEP-1 to the Safety of Care measure group</li> <li>b.) Combining Effectiveness of Care, Timeliness of Care, and Efficient use of Medical Imaging into one group with a weight of 10%</li> <li>c.) Increasing Mortality and Patient Experience measure group weights to 25%</li> <li>d.) Decreasing the Safety of Care and Readmission measure group weights to 20%</li> <li>e.) All metrics should have an equal weighting within a measure group</li> </ul> | John D. Poe, Chair, Quality and Affordability, Mayo Clinic                   | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <ul style="list-style-type: none"> <li>a. CMS should further refine the measure grouping and group weights in a conceptually meaningful way that achieves measure loading balance. 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).</li> </ul>   | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a>   | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>NJHA supports CMS’s proposed new clinical and empirical criteria for creating and maintaining star ratings measure groups. CMS would use a three-step approach: an initial grouping based on clinical coherence, a statistical “confirmatory factor analysis” that explores the extent to which there is a single factor that explains performance in the measure group and ongoing monitoring to ensure balance across the measures within the group.</p> <p>We believe the confirmatory factor analysis would be especially helpful and important to implement. The fundamental premise of the LVM approach used in star ratings is that one can summarize the performance of the measures on an aspect of care (e.g., safety, mortality) into a single score that accounts for both actual performance and unobserved (or latent) performance. One way to test whether that assumption holds true is to use a confirmatory analysis to determine the extent of variation that is explained by the model. Performing this analysis on an ongoing basis would provide a stronger empirical basis for the measure groups, and identify groups that may need to be revised in the future.</p> | Jonathan Chebra,<br>Senior Director,<br>Federal Affairs, New<br>Jersey Hospital<br>Association   | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a>             | Hospital<br>Association | Please refer to the<br>Summary Report |
| 3/29/2019   | Measure Grouping       | <p>Assessment of CMS’s Proposed Changes</p> <p>We recognize that addressing all of the concerns that various stakeholders have with the star ratings is a significant challenge and that not any one proposed change will address all of the elements of concern. However, three of the suggested changes – empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and using an “explicit” scoring approach not tied to the LVM – appear to address partially some concerns and are worthy of further CMS attention. We comment briefly on each of these changes below.</p> <p>New criteria for creating and maintaining measure groups. MHA supports CMS’s 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.</p>  | Patricia M. Noga, PhD,<br>MBA, RN, NEA-BC,<br>FAAN, Vice President,<br>Clinical Affairs,<br>Massachusetts Health<br>& Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital<br>Association | Please refer to the<br>Summary Report |

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| 3/29/2019   | Measure Grouping       | We believe the confirmatory factor analysis would be especially helpful and important to implement. The fundamental premise of the LVM approach used in star ratings is that one can summarize the performance of the measures on an aspect of care (e.g., safety, mortality) into a single score that accounts for both actual performance and unobserved (or latent) performance. One way to test whether that assumption holds true is to use a confirmatory analysis to determine the extent of variation that is explained by the model. Performing this analysis on an ongoing basis would provide a stronger empirical basis for the measure groups and identify groups that may need to be revised in the future. However, if a confirmatory analysis shows that the assumption does not hold true, use of the LVM approach should be replaced with a more reliable and valid approach with empirical evidence to support its use for the intended purpose, and the star ratings should be halted until a new model is in place. | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a>             | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | Proposed Near-Term Updates to the Overall Hospital Quality Star Rating Methodology<br>Measure Grouping<br>CMS solicits feedback on a three-step approach to regrouping, which would include: (1) grouping measures based on clinical criteria; (2) using statistical tests to determine if an important latent quality trait is represented by the measures in the group; and (3) actively following measure groupings for consistency in how much each measure influences the measure group score over time.<br>Ascension believes that incorporating a clearly structured and analytically based approach for rationalizing measure groups is important. The measure groups should not only have face validity in that the measures should all relate to a common issue, but their performance in the LVM and other possible statistical evaluations should be used to determine the appropriateness of the group.   | Peter M. Leibold, Chief Advocacy Officer, Ascension   | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | Measure Grouping – We agree with three step approach.  | Dale N. Schumacher, MD, MPH, President, Rockburn Institute  | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | PSI 90 is a problem. It does not track well with similar measures and often very small numbers at hospital level. At same time we encourage the Option 2 approach (p 23). A Medical Safety group and Surgical Safety group should be encouraged. Surgical reporting will be increasingly reliable.  | Dale N. Schumacher, MD, MPH, President, Rockburn Institute              | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a>     | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <u>a.</u> CMS should further refine the measure grouping and group weights in a conceptually meaningful way that achieves measure loading balance. 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).              | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <u>b.</u> CMS should further refine the measure grouping and group weights in a conceptually meaningful way that achieves measure loading balance.<br><u>c.</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). | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System  | <a href="mailto:maria.iliescu@sinaia.org">maria.iliescu@sinaia.org</a>             | Health System                                   | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment   | Name, Credentials, and Organization of Commenter   | Email Address*   | Type of Organization* | Response*                          |
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| 3/29/2019   | Measure Grouping       | Finally, under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings. To accurately reflect the organizations present-day performance, efforts are needed to ensure the data is current. Additionally, advocacy on the part of CMS is needed to standardize on a national level quality metrics, definitions etc...for all organizations that are using these methods for value based payments (e.g. private insurers) and/or consumerism (e.g. Leap Frog).  | William Lynch,<br>Executive Vice President and Chief Operating Officer,<br>Jamaica Hospital Medical Center | <a href="mailto:BFLANZ@jhmc.org">BFLANZ@jhmc.org</a>                           | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | The groups as they exist now make sense to consumers as features of service quality: will I die, will I get readmitted, will I be safe, will I receive timely care, etc.? The proposals you give are an attempt to change the problem so that the model fits, rather than to provide a correct model that fits the problem at hand. What is the problem? Given a set of measure groupings that make sense to consumers, find sensible weights on the measures that can be used to compute a composite score for every hospital. The problem is not, Given a model, choose a subset of measures and groupings for which the model is valid, and then decide how to weight the groups to reflect consumer interests. The fact that not all measures are correlated with a single latent variable is not a defect of the existing grouping, but an artifact of using a latent variable model that exploits and depends upon correlations. To solve the real problem and maintain the most meaningful groupings for consumers, CMS needs a new approach that is not based on correlation, but some other principles.<br><br>Even if measures in a group are not correlated, patients still care about them. In fact, I would argue that a well-formed group of measures should provide coverage of the patient population across various parts of the hospital and its services, and that an ideal group would have uncorrelated or weakly correlated measures to achieve this. If a measure impacts half of the patient population, but it is not strongly correlated with other measures, it should not be discarded as the LVM may do (see the simple examples given in my paper). | Dan Adelman,<br>Professor, University of Chicago Booth School of Business                                  | <a href="mailto:Dan.Adelman@chicagobooth.edu">Dan.Adelman@chicagobooth.edu</a> | Individual            | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | My proposed approach does not rely on correlation, but instead ensures that weights depend on how much of the population (optionally adjusted for clinical significance) is impacted by each measure, and is based upon comparing a hospital's performance against best performers on an efficient frontier. Thus, under my proposed approach there would be no need to change the measure groupings, or the collection of measures considered, as they exist now. It is flexible to accomodate any alternative measures or measure groupings CMS would like to consider in the future. It would provide a stable model that would not require annual tinkering as you are now proposing. Measures can be freely added, subtracted, or changed over time without concern for having to reconfigure groupings, ensuring that groups can stay relevant and understandable by patients (enabling user-customized weightings as you propose in Section 5.5) and predictable for hospitals.   | Dan Adelman,<br>Professor, University of Chicago Booth School of Business | <a href="mailto:Dan.Adelman@chicagobooth.edu">Dan.Adelman@chicagobooth.edu</a> | Individual            | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | Our users unanimously agreed that Patient Satisfaction should continue to be its own grouping even if the other measures were regrouped. More specifically, although no member of our Patient Family Advisory Council explicitly expressed reservation about grouping all clinical measures into one large domain, they generally thought that the clinical groupings were instructive and should be kept. Our hospital staff in charge of Quality, Patient Satisfaction and Risk expressed interest in further refining the Safety of Care domain to further deal with the problem of measure similarity within a group, and to further refine the PSI 90 indicator into the components (PSI 03, 06, 08 – 15) as described in Option 2 of Table 4 on page 23 in the original request.<br>About 50% of our users thought that the benefit of metric weighting was likely unimportant as long as measures were grouped by clinical similarity and that all measures within a given grouping were weighted equally. They seem to think that specified weights between the groupings will have more impact on the Overall Hospital Quality Star Rating. | Joshua Fetbrandt,<br>Quality Analyst, Tahoe Forest Health System          | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a>     | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>On latent quality trait analysis, approximately 75% of our users said this is important, but that the results then need to be published to the hospitals with each update of data to better advice on future measure (re)grouping. One user felt particularly strong that analysis of latent quality traits was necessary if we are to consider changes in measures, anomalies of care, and improvement activities in future releases for Hospital Compare. The group agreed with this user on a related point, namely that all this analysis should be trended over time and recalculated if measure groupings are adjusted.</p> <p>Multiple users suggested that regrouping on a regular basis would make it tough for hospitals and consumers to understand how the score is being influenced over time, but the collective stated that well-found change should be utilized. The general consensus was that the three-step approach of clinical conformance, confirmatory factor analysis, and ongoing monitoring should be used to define measure groups, especially with eigenvalue and negative loading analysis.</p>  | Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System   | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | <ul style="list-style-type: none"> <li>• We do not agree with the loading as it is currently constructed. It is difficult to understand or explain how the loading coefficients are derived.</li> <li>• The safety of care group is comprised of several metrics that have almost no bearing on the rating of the group at all while one metric completely dominates the score.</li> <li>• The weighting for safety of care needs to be more balanced than it currently sits.</li> <li>• Regrouping does not fix the issue of certain metrics having an extreme impact on the overall rating and others with no impact at all.</li> <li>• The idea of breaking the PSI-90 composite into each PSI metric is a good idea that needs further exploring.</li> <li>• The goal of the groups should be that they are made up of several metrics that all have an opportunity to have an impact on the score in a reasonable fashion with no one single metric driving the entire score.</li> <li>• Option 1 looks fine for the medical, but the surgical section still shows that PSI-90 is completely dominating the score and HAI-3 and HAI-4 have no impact at all.</li> <li>• Option 2 is more balanced than Option 1, but the medical group has PSI-3 at 0.42 and no other metric in this group higher than 0.04.</li> </ul> | Jean Cherry, FACHE, Executive Vice President, Med Center Health | <a href="mailto:jean.cherry@mchealth.net">jean.cherry@mchealth.net</a>     | Healthcare System      | Please refer to the Summary Report |



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| 3/29/2019   | Measure Grouping       | <ul style="list-style-type: none"> <li>• Support the concept of increasing stability, transparency, and predictability.</li> <li>• Creating subgrouping might improve LVM performance. However, these different approaches continue to show inconsistent, imbalanced measure loading coefficients.</li> </ul>  | Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center | <a href="mailto:deede.wang@vumc.org">deede.wang@vumc.org</a>                     | Medical University                         | Please refer to the Summary Report |
| 3/29/2019   | Measure Grouping       | <p>Vizient supports adequate measure assessment and groupings based on clinical coherence, preliminary measure analysis and ongoing monitoring measures for clinical relevance and performance opportunity. Additionally, we support CMS' proposal to use confirmatory factor analysis to determine if latent variable modeling is the appropriate statistical approach.</p> <p>Vizient supports, first and foremost, a more clinically grounded approach by leveraging a well-represented clinical expert panel to identify relevant measures and define clinically meaningful groupings. Vizient cautions CMS in using the balance and consistency of the measure loading coefficients as a measure grouping criteria for several reasons. Firstly, selecting measure groupings based on statistical criteria is likely to misalign with clinical groupings which limit grouping relevance and validity. Secondly, from one reporting period to the next, the model may produce inconsistent measure loading results, ultimately introducing additional measure fluctuations and inconsistencies to the ratings. Finally, measure loading imbalance may be continue regardless of how measures are grouped. Indicating the modeling approach may not be appropriate for the given data and in turn, CMS would be faced with exploring alternative measure loading approaches which, again, add variability and inconsistency to the ratings.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.  | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |



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| 3/29/2019   | Measure Grouping       | <p>CMS seeks feedback on alternative measure groupings for safety of care measures. The regrouping of measures would result in substantial changes to the composition and weight of the measure groups and require further input from stakeholders to evaluate the impact of grouping and weights. The agency should ensure that measure groupings and group weights are balanced and reflect areas of importance to patients. In addition, the implementation of the Meaningful Measures initiative has resulted in the removal of several measures from hospital Compare. CMS should ensure that only measures with NQF endorsement that are valid, reliable and aligned with other existing measures are included in the star ratings.</p> <p>The randomness of the safety of care domain makes it difficult for hospitals to see consistent results over time. The agency should consider classifying the PSI components into separate medical and surgical domains in order to increase the clinical coherence of the measure group. In addition, the PSI-90 measure naturally embeds the AHRQ measure weighting and smoothing which subsequently blocks the consumer from recognizing which measure of care is of most concern. Showing the components as individual performance measures will highlight where randomness occurs and be more useful to the consumer seeking to make care decisions.</p> | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>The FAH supports an approach that ensures periodic re-evaluation of the measure groups, to properly account for the measures being added to and removed from the Star Ratings measure set and to ensure that measure loadings are balanced and positive. As we noted in comments to the Hospital Inpatient Prospective Payment System FY 2019 proposed rule, it is important to consider the impact on Star Ratings when CMS proposes retiring measures from hospital quality reporting programs. While the periodic confirmatory factor analysis would be crucial to provide more empirically sound and consistent measure groups CMS should also consider how measure would cause disruptions to the Star Ratings if removed and provide information on the impact to the ratings if such changes are being considered for public comment.</p> <p>FAH believes that neither grouping option (current or alternatives) is most suitable because they all continue to rely on the PSI-90 measure or its components. FAH continues to urge CMS to consider the removal of these measures from quality programs given ongoing issues with the reliability and validity of the PSI-90 composite and its underlying components. Although FAH recognizes that it is important to include as many measures as possible in the Star Ratings, there is no benefit to including measures that do not result in an appropriate assessment of hospital performance.</p> <p>Beyond this, the FAH notes that in both options presented there are issues with achieving balanced loadings and as such neither option is ideal. The subdivision of the PSI-90 into its component measures would at least increase the level of specificity fed into the model as surgical and medical adverse events require different approaches for improvement. In addition, the direct connection between specific measures and overall ratings allow hospitals to aim for more targeted performance improvement activities with physicians. However, a concern with using the component measures is that the contribution of hospital-associated infection (HAI) measures might be suppressed. The HAI and other safety events are such low frequency events that there is little predictive value from quarter to quarter. The FAH requests that CMS reveal how it would account for these data if PSI-90 is broken down into its component measures, and how CMS would contend with the low predictive values of safety event measures.</p> | Chip Kahn, President, CEO, Federation of American Hospitals | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>APIC does not support the use of composite measures as composite data does not direct the data user to any precise, meaningful topic for improvement or understanding. In fact, composite measures can be misleading. APIC believes that nationally defined and risk adjusted HAI measures should stand alone and not be grouped with other measures, such as PSI-90 which includes non-HAI elements. Therefore, we do not support either of the proposed groupings for the Safety of Care elements.</p> <p>We express concern over the terminology of Medical Safety Group versus Surgical Safety Group. In regard to HAIs, the Surgical Safety reference could lead the public to think it represents all surgeries, when in fact, it represents a limited number of surgical procedures.</p>  | Karen Hoffmann, RN, MS, CIC, FSHEA, FAPIC, President; Association for Professionals in Infection Control and Epidemiology | <a href="mailto:nhailpern@apic.org">nhailpern@apic.org</a>                           | Professional Association | Please refer to the Summary Report |
| 3/29/2019   | Measure grouping       | <p>AHPA believes that the proposed three-step approach to define measure groups is reasonable. However, we recommend that CMS use quantitative instead of qualitative criteria to determine and evaluate the coherence, strength, balance and consistency of measure groups. We also encourage CMS to provide further clarification on the process that would be used to determine clinical coherence when defining measure groups.</p> <p>AHPA believes that the qualitative assessment of the shape of the eigenvalue screen plot can lead to the potential inaccurate inclusion of a group. Consider Figure 3 and Figure 4 of the Public Input Request. Figure 3 passes the ratio test of greater than three. CMS notes that Figure 3 demonstrates a well-constructed mortality group because it displays a prominent turning point at the second eigenvalue, whereas Figure 4 for the safety group does not. However, the prominence of the turning point is dependent on the third eigenvalue and may be on subsequent ones. If the third eigenvalue is closer to the second eigenvalue, the kink is more pronounced even if the ratio is below three. Similarly, if it is much below the second eigenvalue, the kink is flatter even if the ratio is much higher than three. In this situation, it is not clear what a qualitative assessment would find.</p> | Carlyle Walton, FACHE, President; Adventist Health Policy Association   | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System        | Please refer to the Summary Report |

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| 3/29/2019   | Measure grouping       | <p>CMS also proposes to conduct ongoing active monitoring to ensure that measure loadings are balanced within each group and relatively consistent over time. While we commend such effort, there is no clear understanding of how CMS would determine the balance and consistency of new measures, especially for measures for which there is not enough historical data. Based on this issue, AHPA recommends that CMS provide further guidance on how the Agency would determine whether a group is balanced and consistent.</p> <p>The balance and consistency of loadings is crucial to evaluate measure grouping. However, we recommend that statistical criteria be used to determine thresholds. AHPA's response to the question in section 4.2 on the regrouping measures is as follows:</p> <p>AHPA believes that neither the current group nor the alternatives provided are suitable. In Option 2, the surgical safety group ratio of eigenvalues does not meet the conventional threshold of three and is very close to the current eigenvalue. Additionally, the group contains both Healthcare-Associated Infection (HAI) and Patient Safety Indicator (PSI) measures, which use different types of denominators that would cause skewed denominator distribution. This problem is currently present in the Safety of Care group and may also be a problem for readmission grouping, with the introduction of the Excess Days in Acute Care (EDAC) measures. AHPA recommends using an alternative approach to categorize measures into groups by performing factor analysis on different permutations of measures without a priori groupings. This could be done on all measures but especially on safety measures. An approach without a priori assumption might suggest more efficient and statistically sound grouping with all or some of the measures.</p> | Carlyle Walton, FACHE, President; Adventist Health Policy Association | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System      | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>Any time a model is used, its assumptions must be checked and verified. It is of paramount importance for each domain’s latent variable model (LVM) to be re-assessed with every ratings update, namely using factor analysis to determine whether there is indeed a single latent factor underlying the quality measures in each domain. Domains without a single, dominant latent factor are not appropriate for use with a LVM, e.g. the safety domain. Although using the ratio of the first to second eigenvalue (along with visual inspection of the scree plot) is reasonable, it is also important to inspect the factor weights – that is, how does each variable put into the factor model contribute to the first latent factor, the second latent factor, etc.</p> <p>The analyses described regarding the safety domain are consistent with those in our recently published paper on the star ratings (Fontana et al. 2019, <a href="https://journals.lww.com/jbjsoa/Abstract/latest/When_Stars_Do_Not_Align__Over_all_Hospital_Quality.99927.aspx">https://journals.lww.com/jbjsoa/Abstract/latest/When_Stars_Do_Not_Align__Over_all_Hospital_Quality.99927.aspx</a>, also see attached). Our analyses indicated that the safety domain is unstable, particularly when accounting for the fact that the hip and knee complications quality measure is not included for low-volume hospitals performing hip and knee replacements. We impute missing values for this measure for low-volume hospitals (based on the December 2017 data), observing the same “flip” in the safety domain loadings as was witnessed in the July 2018 preliminary release (see attached “StarRatingsJul18_UpdtSpecsRpt.pdf” p21). Quoting our paper: “It seems clear that the safety domain, whether from imputing low-volume hospitals or changing an underlying quality measure, is unstable; therefore, applying a latent variable model to it is problematic.” It is concerning that the LVM appears to be overly sensitive to swings in the underlying quality measures and heavily weighs a single safety measure, ignoring performance on other meaningful measures in the domain. This means these scores do not reflect on-the-ground quality, which is what consumers care about.</p> | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>CMS’s analyses imply there are 2 latent factors underlying the safety domain, meaning that applying a LVM to the entire measure set is unjustified. We agree with the general conclusion and the strategy of trying to subdivide the domain. However, Figures B1 and B2 indicate that there are likely more than 2 latent factors, particularly among the surgical safety group, which itself appears to be composed of 2 factors. With a total of only 4 measures in the surgical safety group, the fact that there are at least 2 latent factors does not bode well for deriving a single latent measure of surgical patient safety. The safety quality measures appear to capture different, distinct facets of patient safety.</p> <p>Overall, it appears these various safety measures cannot be distilled into a single safety latent variable, and even among surgical safety measures, they cannot be distilled into a single latent surgical safety variable. Even when considering the PSI components rather than the PSI-90, Figure B3 and B4 tell a similar story. We would strongly urge CMS to revisit the entire methodology regarding the safety domain. A latent variable model is clearly not an appropriate modeling choice for such heterogeneous safety measures.</p> <p>This is consistent with our recommendation of having procedure- and condition-specific ratings. Safety measures underlying heterogeneous procedures and conditions should hardly be expected to have some underlying meta-safety factor. Different measures are relevant and important for different reasons depending on the procedure and condition.</p> | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                       | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | However, we believe that only three of the proposals should be pursued further at this time: 1) empirical criteria for measure groups; ...  | Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources   | <a href="mailto:joelballew@texashhealth.org">joelballew@texashhealth.org</a> | Healthcare System      | Please refer to the Summary Report |

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| 3/29/19     | Measure Grouping       | In terms of cohesion of the measures in a domain, I'm not convinced that either of the two regroupings CMS considered are clinically robust, while CMS demonstrates that there is mixed results in terms of statistical robustness of the potential regroupings. While I think that splitting surgical and medical safety into two different domains makes sense clinically, I also think CMS should look to see what other measures could be included to make the domains more statistically robust (instead of relying on merely splitting up the measures in the current combined domain).<br>As for the weighting issue, seems to be addressed by changes in how precision is handled (next feedback item) | Laura Morris, MS, CPHQ, Senior Business Analyst for Quality                             | <a href="mailto:lmorris@glensfalls.hosp.org">lmorris@glensfalls.hosp.org</a>       | Individual            | Please refer to the Summary Report |
| 3/29/19     | Measure Grouping       | Use of the PSI-90 composite obscures understanding of individual PSI performance, as well as the conditions or procedures to which a given PSI applies. An individual PSI component may dominate the Safety of Care score. The option presented with PSI component scores partitioned into a Medical Safety group and a Surgical Safety group, further modified by stabilizing components through an explicit approach to calculating scores, would better meet the objective of summarizing information "in a way that is...easy for patients and consumers to interpret."  | Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care | <a href="mailto:hahncoverk@health.missouri.edu">hahncoverk@health.missouri.edu</a> | Medical University    | Please refer to the Summary Report |

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| 3/29/2019   | Measure Grouping       | <p>Criteria for Evaluating Measure Groups</p> <p>CMS proposes to use a three-step process to evaluate the star ratings measure groups, building on the current approach that relies solely on clinical coherence, as described in the table below.</p> <p><a href="#">[Table 10]</a></p> <p>GNYHA supports the proposed three-step approach to establishing measure groups, including the consideration of balance and consistency of measure loadings. We believe that this will improve the empirical basis for the measure groups.</p> <p>Proposals to Improve Balance, Consistency, and Model Fit</p> <p>CMS’s assessment of the Safety of Care measure group identified significant deficiencies in the latent variable model, including: 1) the group’s measure loadings lack consistency over time, suggesting a weaker underlying latent variable model compared to other measure groups, and 2) PSI 90 has a significantly larger loading than other measures, such as the hospital infection measures, creating an imbalance among measures within in the group.</p> <p>CMS proposes several potential changes to improve the model fit and address these issues, but unfortunately, it provided insufficient detail or data for stakeholders to fully evaluate the proposals and offer concrete recommendations. Our preliminary assessment, based on the limited information released by CMS, is that the proposals will be inadequate to substantively improve the model.</p> <p>Therefore, CMS should conduct thorough additional exploratory and confirmatory factor analysis to evaluate the validity of the Safety of Care measure group latent variable model and publish the analytical results for stakeholder review and comment. In addition, GNYHA strongly urges CMS to convene a panel of experts in structural equation models/latent variable models to review and strengthen the rigor of the star ratings methods generally.</p> | Elisabeth R. Wynn,<br>Executive Vice<br>President, Health<br>Economics &<br>Finance, Greater<br>New York Hospital<br>Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a> | Hospital<br>Association | Please refer to the<br>Summary Report |



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| 3/11/2019   | Incorporating Measure Precision | Reliability of each measure should be accounted for, although CMS definition of loading as: “Empirical estimates from LVM representing the contribution of each individual measure; a higher loading indicates measures that are more correlated with each other and with the underlying aspect of quality” implies that higher loading is indicative of quality whereas your description under Incorporating Measure Precision implies that loading is the “amount that each measure contributes to the measure group score” and is more indicative of volume for that hospital.   | Rhonda Unruh, MHA, RN, CIC, Vice President of Quality, Guadalupe Regional Medical Center | <a href="mailto:runruh@grmedcenter.com">runruh@grmedcenter.com</a>                     | Individual             | Please refer to the Summary Report |
| 3/6/2019    | Incorporating Measure Precision | Confidence Interval Weighting   | Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare             | <a href="mailto:RHyke@stanfordhealthcare.org">RHyke@stanfordhealthcare.org</a>         | Individual             | Please refer to the Summary Report |
| 3/12/2019   | Incorporating Measure Precision | Please address the Safety of care measure group inappropriate weighting. The latent variable model disproportionately weights the recently modified PSI90 metric. A recent study by Rush showed PSI 90 was weighted 1,010 times stronger than the catheter-associated urinary tract infections measure, 81 times stronger than the C. difficile infection rates measure, 51 times stronger than the central line-associated bloodstream infection rates measure and 20 times stronger than the surgical site infection rate measure for CMS stars. Considering the HACRP program gives the PSI90 metric a 15% weight compared to the 85% weight of infections, the weighting created by the LVM is not appropriate. Also, the inequity in the LVM weighting towards PSI90 is also antithetical to the CMS stance of caution around the modified PSI90 in its removal from VBP until 5 years of data is collected. | Adam Felton, MS, Manager: Clinical Information Analysis, Norton Healthcare               | <a href="mailto:Adam.Felton@nortonhealthcare.org">Adam.Felton@nortonhealthcare.org</a> | Individual             | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure          | Text of Comment  | Name, Credentials, and Organization of Commenter   | Email Address*   | Type of Organization* | Response*                          |
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| 3/14/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>Do you have any concerns about changing the methodology to use a combination of denominator weighting and log {denominator} weighting, based on the type of measure?</li> </ul> <p>This specific option would be an improvement, but an even better improvement would be to move to an explicit, simple weighting system driven by the broad concept of relative clinical significance of measures in a category. Pure equal weighting would be an example of an explicit, simple system, but not all measures in a category are of equal importance to patients.</p> <p>This line of thinking reflects our broad concern about linking weights to concepts of reliability or precision of measures. Focusing on reliability or precision creates the very real risk of linking Star ratings to common but clinically unimportant events (e.g., accidental lacerations that may not even be noticed by patients) rather than very significant events (e.g. mortality). We understand the rationale for linking weights to concepts of reliability or precision, but we feel that linking weights to clinical significance first, and then perhaps reliability or precision second, would add value to the Star Rating system.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a>                               | Health System         | Please refer to the Summary Report |
| 3/18/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>Capping the impact of volume adjustment and incorporating confidence intervals would address issues with volume affecting rates.</li> </ul>   | Autumnjoy Leonard, Clinical Quality Compliance Auditor, Summit Healthcare Regional Medical Center        | <a href="mailto:aleonard@summithealthcare.net">aleonard@summithealthcare.net</a> | Hospital              | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure          | Text of Comment   | Name, Credentials, and Organization of Commenter                                      | Email Address*   | Type of Organization* | Response*                          |
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| 3/21/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>Do you have any concerns about changing the methodology to use a combination of denominator weighting and log (denominator) weighting, based on the type of measure?</li> </ul> <p>Yes. It appears that denominator weighting results in measures having different weights for different hospitals. Although there is a broad range of types of hospitals and patients served, not measuring hospitals the same way does not yield a good comparison. The log weighting is complicated, very technical, and adds to the complexity of determining opportunities for improvement. Use of the confidence interval weighting is preferred. CMS has expressed a desire and intent to move towards more outcome measures. This would increase the number of measures that confidence intervals could be utilized for.</p> <ul style="list-style-type: none"> <li>Do you have any concerns about applying a change to the weighting approach across all measure groups (where data are available) vs. applying the change only to measure groups that meet specific criteria?</li> </ul> <p>No. Different types of measures may require different methods. This may be needed with the confidence interval method.</p> | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health  | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System         | Please refer to the Summary Report |
| 3/22/19     | Incorporating Measure Precision | WHA agrees that incorporating measure precision (where possible) should be considered by CMS. However, none of the approaches articulated in the request document provide a definite advantage over another. WHA's concern is for the accuracy and reliability of more complicated approaches to incorporating measure precision. Regardless of the method adopted, transparency and independent audit of the results will assist stakeholders in being assured of accurate calculations.   | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a>                                   | Hospital              | Please refer to the Summary Report |
| 3/25/19     | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Alison L. Hong, MD, Chief Quality Officer, St Peter's Health Partners                 | <a href="mailto:Alison.Hong@trinity-health.org">Alison.Hong@trinity-health.org</a>             | Health System         | Please refer to the Summary Report |

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| 3/25/2019   | Incorporating Measure Precision | Specific to measure precision in assessing quality outcomes, the assumption that a larger denominator (more patients) is equivalent to increased measure precision may be a logic error. If a hospital has enough volume to make the data for the measure statistically valid, then it should be included. If there is not enough volume to be statistically valid, then the measure should not be included and reported. In a medium sized hospital such as Benefis, a larger denominator does not necessarily equal a more precise measure. For example, given the rural nature of our state and smaller population, our denominator for the CLABSI measure may be considered “lower volume”. But if our CLABSI rate was 10%, we clearly would have a significant quality of care issue. If this is true, then the reverse is also true. If we have zero CLABSIs in a population where we are risk adjusted to have 2%, then we are providing excellent care and need to be recognized for that fairly in the methodology. We know that “low volume” can cause some volatility in outcomes trends at times, but if we provide excellent care, the trend will ultimately reflect that. If all reported outcomes measures are important to CMS and to our healthcare consumers, then an adjustment in the equation that tries to artificially determine “precision” based on volume, just does not make sense. | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System   | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a>                         | Health System          | Please refer to the Summary Report |
| 3/26/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Sharon Johnson, MBA, CPHQ, CPPS, Director of Quality Management, Utilization Management and Patient Safety;<br>Highland Hospital of Rochester | <a href="mailto:Sharon.Johnson@URMC.Rochester.edu">Sharon.Johnson@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |

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| 3/26/2019   | Incorporating Measure Precision | Under the current modeling, PSI-90 has a disproportionate impact on the overall domain Safety of Care score. As a result, scores are driven by the flawed measure (which is easily gameable by hospitals) and effectively ignore performance on other meaningful measures in the domain. I agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Pat Reagan Webster, PhD CPPS, Associate Quality Officer; Strong Memorial Hospital; Associate Professor, Public Health Sciences; University of Rochester | <a href="mailto:patricia_reagan@urmc.rochester.edu">patricia_reagan@urmc.rochester.edu</a> | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Incorporating Measure Precision | -Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. Some would ask for CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings. Do not do this either. Get rid of the measure which was never meant to be used to compare hospitals to one another, and also, was never meaningful as a quality of care measure. Too many factors rolled into one. Separate out the PSI into individuals and test each one on its' own merit to include or not. You do not include an overall aggregate of all HCAHPS into one single measure, why would you do it for PSI when there is a better way? | Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital   Quality Management Dept.                          | <a href="mailto:scrimet@amc.edu">scrimet@amc.edu</a>                                       | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Michele Walsh, MSN, RN, CNO; Ascension  | <a href="mailto:Michele.Walsh@ascension.org">Michele.Walsh@ascension.org</a>               | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>• <b>Measure Precision:</b> WHA agrees that incorporating measure precision (where possible) should be considered by CMS. However, none of the approaches articulated in the request document provide a definite advantage over another. WHA's concern is for the accuracy and reliability of more complicated approaches to incorporating measure precision. Regardless of the method adopted, transparency and independent audit or the results will assist stakeholders in being assured of accurate calculations.</li> </ul>   | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association   | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                                     | Hospital Association   | Please refer to the Summary Report |

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| 3/26/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI- 90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Kathy Parrinello PhD, Executive Vice President and COO; Strong Memorial Hospital, University of Rochester Medical Center | <a href="mailto:Kathy_Parrinello@URMC.Rochester.edu">Kathy_Parrinello@URMC.Rochester.edu</a> | Individual            | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Daniel J. Baker, MD, MBA, Medical Director,Lenox Hill Hospital   | <a href="mailto:djbaker@northwell.edu">djbaker@northwell.edu</a>                             | Individual            | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Accuracy. The ratings should be based on rigorous quality measures, and employ appropriate and correctly-executed statistical approaches to combining performance across measures. Users and hospitals should expect that differences in star ratings across hospitals should be substantiated by clinically and statistically meaningful differences in underlying performance. As currently designed, star ratings continue to include measures with known methodological flaws (e.g., the patient safety indicator (PSI) composite measure). And concerns have been raised in the past about whether the LVM calculation was being executed correctly. Stability. Any fluctuations in star ratings across reporting periods should be driven by significant changes in underlying measure performance rather than by any inherent instability in the ratings methodology. As advised by the AHA, CMS canceled the July 2018 update to star ratings in part because there were significant changes in star ratings. These rating changes were not explained easily by a major change in underlying measure performance. | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association              | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>                                       | Hospital Association  | Please refer to the Summary Report |

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| 3/27/2019   | Incorporating Measure Precision | <p>Balanced assessment. Star ratings performance should be based on performance across the breadth of available measures, and not hinge disproportionately on only one or two measures. As noted in the public comment document, the PSI composite measure and hip/knee complication measure have historically dominated the score of the safety measure group, even though the infection measures likely represent higher priority issues.</p> <p>Confidence interval-based measure weights. The AHA agrees with CMS that the weights applied to the measures used in the LVM 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. Based on the information available in the public comment document and communications we have had with experts in LVM, we believe the current approach “over-fits” the model and is methodologically wrong. We believe that by working with experts in LVM, it will be possible for CMS to develop a solution to this problem that is both mathematically correct and leads to a more rational approach for addressing measurement precision in star ratings, thereby improving the ratings accuracy, stability and balance.</p> <p>In the star ratings LVM approach, CMS calculates 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 the AHA and others have repeatedly noted, the loading factors within the patient safety measure group have fluctuated significantly, even though performance on the underlying measures has not appreciably changed. Furthermore, two measures in particular – the PSI composite measure, and hip/knee complications – have a disproportionate influence on the safety score, even though the infection measures within the safety group arguably reflect more significant safety issues.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/27/2019   | Incorporating Measure Precision | <p>CMS asserts that at least some of the loading factor fluctuation and imbalance stem from the agency’s approach to dealing with measure precision. CMS’s current calculation of the LVM uses “denominator weights” in which hospitals are scored more heavily on measures that include larger numbers of patients. CMS offers three alternative approaches to this issue – confidence interval-based weights (in which the weights account for the confidence intervals of each measure’s calculation), logarithm of the denominator-based weights and simply eliminating the denominator weights altogether.</p> <p>CMS indicates that its preference would be to use a combination of current denominator weights and logarithm of the denominator weights. However, the data in the public comment document show that the confidence-interval based weights best improve the LVM model fit for the safety group, as well as the balance and stability of the safety measure group’s loading factors. The AHA is concerned that continuing to use the current approach of denominator-based weights would only perpetuate the problems with star ratings.</p> <p>Whatever other decisions are made about the calculation of the LVM, it first must be mathematically correct. We understand CMS and its contractor are trying to make it so, and we appreciate the staff’s diligent efforts. There are LVM experts at many colleges and universities. We have shared the name of one such expert with CMS previously, and would be glad to provide additional names of experts and urge the agency to reach out to them.</p> <p>Validation of computational approach. The AHA urges CMS to engage a group of experts on LVM to ensure its calculation approach is executed correctly. We greatly appreciated CMS’s 2017 decision to suspend star ratings briefly and make some changes to how it was executing the existing methodology after discovering that some issues led to the misclassification of hospitals. Unfortunately, we believe there still may be problems leading to misclassification. This includes the need to correct the individual measure loading factors, but not by using confidence interval weightings as discussed above.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/27/2019   | Incorporating Measure Precision | Readmissions measure outliers. The AHA urges CMS to explore strategies to mitigate the impact of outliers in calculating the readmission measures used in star ratings. A recent analysis from a team based at Rush University Medical Center showed that hospital performance on the readmission measure can be impacted dramatically by highly medically complex patients who require frequent re-hospitalizations. CMS could consider including additional exclusions in its readmission measure to ensure those hospitals caring for the most complex patients are not placed at an unfair disadvantage | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association                 | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>                                     | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Karen Carey, Interfaith Medical Center  | <a href="mailto:KCarey@INTERFAITHMEDICAL.org">KCarey@INTERFAITHMEDICAL.org</a>             | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Kim Clement, Quality Analysis   | <a href="mailto:kclement@cmhhamilton.com">kclement@cmhhamilton.com</a>                     | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Daniel Lombardi, DO, MBA, FACOEP, VP/Chief Quality Officer, Associate Medical Director, St. Barnabas Hospital Health System | <a href="mailto:dlombardi@sbhny.org">dlombardi@sbhny.org</a>                               | Health System          | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Would advocate for increased precision/accuracy over existing model   | Larry Mandelkehr, Executive Director, Hospital Quality and Innovation, UNC Health Care System                               | <a href="mailto:Larry.Mandelkehr@unchealth.unc.edu">Larry.Mandelkehr@unchealth.unc.edu</a> | Health System          | Please refer to the Summary Report |

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| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Sean Fadale, FACHE<br>President and CEO<br>Community Memorial Hospital   | <a href="mailto:SFadale@Seancmh.hamilton.com">SFadale@Seancmh.hamilton.com</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. I agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Beth Falder, Health Quest  | <a href="mailto:bfalder@Health-quest.org">bfalder@Health-quest.org</a>         | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Amir K. Jaffer, MD, MBA<br>Chief Medical Officer,<br>New York Presbyterian<br>Queens Hospital                                      | <a href="mailto:ajaffer@nyp.org">ajaffer@nyp.org</a>                           | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Kurt Kodroff   | <a href="mailto:KKodroff@kingsbrook.org">KKodroff@kingsbrook.org</a>           | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI- 90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings. | Jacel Kouns, MS, RN, NEA-BC, FACHE<br>Executive Director -<br>Montefiore Mount<br>Vernon<br>Vice President of<br>Clinical Services | <a href="mailto:JKOUNS@montefiore.org">JKOUNS@montefiore.org</a>               | Individual             | Please refer to the Summary Report |

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| 3/27/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | LuAnne Roberts  | <a href="mailto:lroberts@wcchs.net">lroberts@wcchs.net</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | MHA generally agrees that accounting for variable precision among measures is an important consideration and has no specific concerns about changing the methodology to use a combination of denominator and log denominator weighting all measure groups to help achieve greater balance among constituent item loadings derived from latent variable models.   | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Incorporating Measure Precision | MHA believes that the complex set of conceptual tradeoffs involved with selecting between weighting approaches is, in large part, a function of the methodologic complexity of the latent variable modeling approach currently used in the derivation process. In this approach, precision weights become inextricably entangled with item loadings that are themselves a function of the shared variation among items. We believe that the opaqueness of this methodology presents unnecessary impediments to the usefulness of Star Ratings that could be overcome with a simpler, more transparent approach using less sophisticated methodologies. | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/28/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>Incorporating Precision of Measures: CMS should continue to analyze and share more information on potential approaches to improving the incorporation of measure precision in the ratings and be transparent in advance of implementing changes.</li> </ul> <p>Incorporating Precision of Measures</p> <p>Currently, CMS uses a denominator weighting to account for differences in measure score precision. Further analysis of this approach has revealed that in addition to reflecting sample size differences, denominator weighting may also contribute to the imbalance of measure loadings and worsen model fit, but that the cause of this effect is unknown. CMS has considered three alternative weighting options to account for precision of the measure: (1) Confidence interval weighting; (2) Log (denominator) weighting for non-volume denominators, otherwise use of denominator weights; and (3) No weighting (equal weighting). CMS notes that none of options is without disadvantages (primarily expected shifts in ratings or lack of intuitive support), but believes that incorporating measure precision into the ratings is conceptually important. We note that the alternative approaches often demonstrated large, unexplained changes in measure loadings over time, such as for the hip/knee complication rate in the confidence interval weighting. We are concerned that CMS does not fully understand the reasons for differences across different denominator weighting, and caution against any action before further analysis. The AAMC agrees that measure precision is critical to the ratings, but insufficient data and specific details are available to assess the options. CMS should continue to analyze and understand approaches to improving the incorporation of measure precision in the ratings, and be transparent in advance of implementing any changes.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Incorporating Measure Precision | <b>4.3 Incorporating Precision of Measures</b><br><b>Questions for the Public:</b><br>Do you have any concerns about changing the methodology to use a combination of denominator weighting and log (denominator) weighting, based on the type of measure? <b>No concerns about changing the methodology if the current type of model (LVM) is maintained. . The log transformation makes sense to apply for skewed distributions.</b>  | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Incorporating Measure Precision | Do you have any concerns about applying a change to the weighting approach across all measure groups (where data are available) vs. applying the change only to measure groups that meet specific criteria? <b>The document only showed the effect of the log transformation to the Safety of care domain. I am not sure if the change would be minimal or drastic if applied across all measure groups. Applying the change only to measure groups that meet specific criteria seem appropriate, since the loadings for the other measure groups were stable and well-balanced. Again, this change is only relevant if CMS chooses to stay with the current model. See comments above.</b><br>Are there other approaches that CMS should consider? <b>See comments above regarding the application of an explicit model.</b> | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/28/2019   | Incorporating Measure Precision | <p>We have concerns keeping the current practice of using the measure’s denominator to precision weight as it has contributed to the poor balance of measures in the Safety Domain. While the Public Input Request provides statistical data on log (denominator) and no precision weighting for the Safety Domain, it would be impossible for RUMC to provide a recommendation without seeing data for all other domains.</p> <p>These statistical methods are making the Overall Rating program far too complicated for hospitals and consumers to understand the system. The recommendations in the Public Input Request do not resolve these issues. These problems would be resolved by abandoning the LVM for more straight forward weighting.</p> | <p>Dr. Omar Lateef<br/> Stuart Levin, MD<br/> Presidential Professor of Rush University<br/> Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br/> Rush University Medical Center<br/> Chicago, Illinois<br/> Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine<br/> Thomas A. Webb, MBA<br/> Manager, Quality Improvement; Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University    | Please refer to the Summary Report |

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|-------------|---------------------------------|---|---|--|------------------------|------------------------------------|
| 3/29/2019   | Incorporating Measure Precision | In addition, Spectrum Health Hospitals have worked to account for varying populations across measures, but it is very difficult, as confidence intervals vary.  | Leslie M. Jurecko MD, MBA<br>SVP, Quality, Safety, and Experience<br>Spectrum Health<br>Pediatric Hospitalist<br>Assistant Professor of Pediatrics at Michigan State University,<br>College of Human Medicine | <a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a>   | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Sameh Samy, MBBCh, MSA, CPHQ, AVP, Quality Management Dept., Maimonides Medical Center  | <a href="mailto:APollack@maimonidesmed.org">APollack@maimonidesmed.org</a>                 | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings. To accurately reflect the organizations present-day performance, efforts are needed to ensure the data is current. Additionally, advocacy on the part of CMS is needed to standardize on a national level quality metrics, definitions etc...for all organizations that are using these methods for value based payments (e.g. private insurers) and/or consumerism (e.g. Leap Frog). | Sharon L. Narducci<br>DNP, APRN-BC, CCRN, Chief Quality Officer, Jamaica Hospital Medical Center, Flushing Hospital Medical Center  | <a href="mailto:SNARDUCC@jhmc.org">SNARDUCC@jhmc.org</a>                                   | Individual             | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | and should continue to analyze and share more information on potential approaches to improving the incorporation of measure precision in the ratings.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health  | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System          | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure          | Text of Comment   | Name, Credentials, and Organization of Commenter  | Email Address*   | Type of Organization* | Response*                          |
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| 3/29/19     | Incorporating Measure Precision | Rigorous ongoing statistical review must be applied to any possible grouping changes to ensure that measures do not disproportionately and inappropriately impact the grouping's overall score. The same rigor must be applied to the use of measure precision approaches and to fairly define weights. The current use of denominator volumes does not accurately reflect overall care provided across clinical conditions, as some conditions inherently have higher volumes than others, but should not be weighed more heavily in an overall score. | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health                            | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System         | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | Advocate Aurora agrees that incorporating measure precision (where possible) should be considered by CMS. Regardless of the method adopted, transparency and independent audit of the results will assist stakeholders in being assured of accurate calculations.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health                            | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Measure Precision: As we understand the current calculation of the CMS Overall Quality Hospital Star ratings, the use of denominator-based weighting (or reliability-adjusted weights) produces the scenario of different relative weights being assigned to the same measure for different hospitals. This approach results in hospitals not being compared in a true apples-to-apples fashion. We recommend that CMS move toward assigning fixed weights to the individual measures.  | Allen Kachalia, MD,<br>JD, Senior Vice President, Patient Safety and Quality,<br>Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a>                                     | Health Organization   | Please refer to the Summary Report |



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| 3/29/2019   | Incorporating Measure Precision | <p>CMS has sought to quantify the benefits and disadvantages of denominator weighting and evaluated other alternative approaches for incorporating measure score precision into the Overall Hospital Quality Star Ratings, including weighting by the logarithm of the denominator, confidence interval-based weighting or removing weighting altogether.</p> <p>Under the current Star Ratings model, the measure loadings (or general importance of each measure) in the Safety of Care domain are incredibly lopsided. As a result, group/domain score estimates for this domain rely heavily on the flawed PSI-90 measure and effectively ignore performance on meaningful quality measures such as catheter-associated urinary tract infection, central line-associated bloodstream infection and other hospital-acquired infection measures in the domain.</p> <p>HANYS supports CMS' proposal to move to either log-transformation or confidence interval weighting. Shifting to log-transformation of measure denominators improves statistical modeling by accounting for the skew in the distribution of hospital volumes in most HAI measures.</p> <p><i>As shown above <a href="#">[Figure 5]</a>, log-transformation improves statistical modeling by adjusting for the skew in the original distribution of hospital device days on the CLABSI measure.</i></p> <p>Shifting to confidence interval weighting helps account for the large confidence intervals on many hospitals' PSI-90 composite measure due to lower case counts and statistical methods incorporated into the PSI-90 composite. As demonstrated by the estimated measure loadings for each scenario, both proposals ensure more balanced measure loadings within this domain and correct for the fact that these measures come from very different data sources.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State               | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.   | Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center | <a href="mailto:ALutz@RUMCSI.org">ALutz@RUMCSI.org</a>   | Medical University    | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Cheryl Feeman Macafee, MBA, CPHQ, RHIA, Director of Quality Management   | <a href="mailto:MacafeeC@jmhn.org">MacafeeC@jmhn.org</a>                                   | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Wendy Blakemore MS, BSMT (ASCP), Director of Quality, Patient Safety and Utilization Management, Thompson Health | <a href="mailto:Wendy.Blakemore@thompsonhealth.org">Wendy.Blakemore@thompsonhealth.org</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings.  | Karen Bonilla, Senior Governmental Affairs Specialist, PAC Manager at Healthcare Association of New York State   | <a href="mailto:KBonilla@hanys.org">KBonilla@hanys.org</a>                                 | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | First, under the current modeling, one measure in the Safety of Care domain has an overly weighted impact on the overall domain score and is confusing as the measures should have equal weight. As a result, scores are driven by the flawed PSI-90 measure and effectively ignores performance on other meaningful measures in the domain. Because of this, we agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings. | Ronette Wiley, Executive Vice President & Chief Operating Officer, Bassett Medical Center                        | <a href="mailto:jackelyn.fleury@bassett.org">jackelyn.fleury@bassett.org</a>               | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | No concern about changing to combo methodology, as those that dig deep enough to understand precision would likely understand need for different approaches. Believe the weighting should best suit the data. The groups, in some cases, represent very different data and thus methods to incorporate precision would naturally differ.   | Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health                                | <a href="mailto:kathleencarrothers@gmail.com">kathleencarrothers@gmail.com</a>             | Individual             | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | RWHC believes the current method of Measure Precision by weighting the measures based on the volume for the facility provides a more accurate picture of the quality of care provided by the hospital than not weighting the score based on volume. Small rural hospitals are greatly impacted by low volumes and without considering the volume per measure they could appear to provide a lower quality of care than what they actually do. We would not be in favor of removing/changing the weighting of measures by volume.  | Tim Size, Executive Director, Rural Wisconsin Health Cooperative   | <a href="mailto:JLevin@rwhc.com">JLevin@rwhc.com</a>           | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | We believe that accounting for precision with shrinkage estimators is essential. However, the choice of estimator is difficult and depends on the goal. There is little difference between denominator weighting and CI weighting in the model fit data, but denominator weighting is more transparent and can be applied more consistently across measures. Log denominator weighting does provide more balanced measures loadings than denominator weighting. However, it is not clear to us why balanced loading is a fundamentally important concept; there is no reason to a priori assume that there should be equality between, for example, CAUTI and the PSI-90.   | Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan | <a href="mailto:svijan@med.umich.edu">svijan@med.umich.edu</a> | Medical University                              | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | The public input request notes that CMS is considering changing the way scores' precision is weighted in the statistical model and seeks feedback regarding whether the reliability of each measure should be accounted for in some way. Currently, the measure's denominator, which is often the number of patients, is used. Kaiser Permanente agrees that attention should be paid to ensuring that individual measures have high degrees of precision when possible. At this time, and until a workable alternative can demonstrate better results, we support using the measure's denominator. CMS should also consider inclusion of confidence intervals and limitation of outliers in measure weighting as part of its strategy. | Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals  | <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a> | Hospital Association                            | Please refer to the Summary Report |

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| 3/29/19     | Incorporating Measure Precision | As opposed to changing the approach to denominator weighting across all measures, Cedars- Sinai recommends that CMS consider increasing the minimum number of measures reported by each hospital. Part of the instability in measure loadings may be caused by the inclusion of hospitals that barely meet the criteria for the required number of measures. Because of the latent variable approach, the inclusion of these hospitals makes the ratings less reliable for all hospitals. An increase in the minimum number of measures would make the measure loadings more balanced and more stable. | Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center   | <a href="mailto:gail.grant@cshs.org">gail.grant@cshs.org</a>                             | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | Measure precision into the Rating is conceptually and critically important. Insufficient data and specific details are not available to assess the options. CMS needs to continue to understand the reasons for differences across different weightings, be transparent, and caution against any action before further analysis.   | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital                 | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | ZSFG supports revision of weights applied to measures used in the LVM. We believe it is not appropriate for the claim-based PSI-90 measures, or the hospital-wide readmissions measure, to be so disproportionately weighted they drown out the effect of other equally meaningful measures in safety and readmissions. ZSFG believes CMS should re-examine the underlying methodology of the star ratings to improve their reliability, predictability, and accuracy.   | Troy Williams, RN, MSN, Chief Quality Officer; Zuckerberg San Francisco General Hospital and Trauma Center | <a href="mailto:leslie.safier@sfdph.org">leslie.safier@sfdph.org</a>                     | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | We have no strong opinion for the options in table 12. However, we support the need to change from the denominator weightings due to the current disadvantages. Our Infection Prevention department supports the volumes-based denominators for the HAI measures as this is already reported through NHSN and is incorporated into the SIR calculation as well.  | Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital                              | <a href="mailto:linnea.huinker@northmemorial.com">linnea.huinker@northmemorial.com</a>   | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <p>4.3. Incorporating Precision of Measures</p> <p>Do you have any concerns about changing the methodology to use a combination of denominator weighting and log (denominator) weighting, based on the type of measure?</p> <p>- Yes. An inconsistent approach to weighting measures within an LVM is disconcerting. Within any LVM, the same weighting method should be applied uniformly to all measures. However, it is reasonable that various weighting methodologies be applied to different LVMs.</p> <p>Do you have any concerns about applying a change to the weighting approach across all measure groups (where data are available) vs. applying the change only to measure groups that meet specific criteria?</p> <p>- A change in weighting method may be applied only to measure groups that meet specific criteria because the methodology then calculates the summary score using arbitrarily assigned weights for group scores.</p> <p>Are there other approaches that CMS should consider?</p> <p>- Yes. When the LVM does not work out to our satisfaction, the authors could replace a given LVM with an explicit approach to group score calculation (such as an average of measure scores). For example, this may be an option for the Safety of Care group of measures due to the measure group's low convergence rate.</p> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a>                 | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | <p>Measure precision: Under the current modeling, one measure in the Safety of Care domain has a disproportionate impact on the overall domain score. As a result, scores are driven by the flawed PSI-90 measure and effectively ignore performance on other meaningful measures in the domain. We agree with CMS' proposal to incorporate either log transformation and/or confidence interval weighting to ensure balanced measure loadings, if publication of the Overall Star Rating Scores will continue.</p>  | <p>Kathleen R. Reilly, B.S., RRT, CCMSCP<br/>Director, Quality and Performance Improvement<br/>Finger Lakes Health (Geneva General Hospital/Soldiers and Sailors Memorial Hospital)</p>   | <a href="mailto:Kathleen.Reilly@fingerlakeshealth.org">Kathleen.Reilly@fingerlakeshealth.org</a> | Individual            | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | Measure precision: Under the current modeling, PSI-4 in the Safety of Care domain has a disproportionate impact on the overall domain score. This is a flawed measure that does not accurately reflect what it was intended to measure. This measure effectively disincentivizes hospitals from expanding cardiac shock programs, implantation of Impella heart pumps, and offering interventional neurology as an option for our sickest patients on admission. | Diane C. Kantaros, M.D.<br>Corporate AVP of Clinical Quality<br>Health Quest  | <a href="mailto:dkantaros@Healthquest.org">dkantaros@Healthquest.org</a> | Individual                                      | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | 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.       | Alyssa Keefe, Vice President of Federal Regulatory Affairs,<br>California Hospital Association                      | <a href="mailto:nhoffman@calhospital.org">nhoffman@calhospital.org</a>   | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | We do not recommend a replacement for the current denominator-based precision approach, although we generally support any statistical improvements which validly address any metrics where low precision may be causing substantial bias or variation in star ratings.   | John D. Poe, Chair, Quality and Affordability, Mayo Clinic  | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a>   | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | The Joint Commission is in favor of changing the way that each measure's and hospital's score precision are weighted within the statistical model to better balance the loadings within the measure grouping. A combination of denominator weighting and log (denominator) weighting—based on the type of measure—would provide the best balance of the loadings within measure groupings.   | Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission | <a href="mailto:PRoss@jointcommission.org">PRoss@jointcommission.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | With respect to measure precision, while KHA agrees that having a higher loading factor for measures in which a hospital has more patients seems intuitive, hospitals have legitimate concerns that the loading factor may have the potential to have an overly sensitive impact on overall score and caution should be used in “over-loading” measures which then does not provide reliable or accurate information.  | Karen Braman, Senior Vice President, Healthcare Strategy and Policy<br>Kansas Hospital Association                  | <a href="mailto:kbraman@khanet.org">kbraman@khanet.org</a>               | Hospital Association                            | Please refer to the Summary Report |



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| 3/29/2019   | Incorporating Measure Precision | <p>NJHA agrees with CMS that the weights applied to the measures used in the LVM 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. By working with experts in LVM, it will be possible for CMS to develop a solution to this problem that is both mathematically correct and leads to a more rational approach for addressing measurement precision in star ratings, thereby improving the ratings accuracy, stability and balance.</p> <p>In the star ratings LVM approach, CMS calculates 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. However, the loading factors within the patient safety measure group have fluctuated significantly, even though performance on the underlying measures has not appreciably changed.</p> <p>Furthermore, two measures in particular – the PSI composite measure, and hip/knee complications – have a disproportionate influence on the safety score, even though the infection measures within the safety group arguably reflect more significant safety issues.</p> <p>CMS asserts that at least some of the loading factor fluctuation and imbalance stem from the agency’s approach to dealing with measure precision. CMS’s current calculation of the LVM uses “denominator weights” in which hospitals are scored more heavily on measures that include larger numbers of patients. CMS offers three alternative approaches to this issue – confidence interval- based weights (in which the weights account for the confidence intervals of each measure’s calculation), logarithm of the denominator-based weights and simply eliminating the denominator weights altogether.</p> <p>CMS indicates that its preference would be to use a combination of current denominator weights and logarithm of the denominator weights. However, the data in the public comment document show that the confidence-interval-based weights best improve the LVM model fit for the safety group, as well as the balance and stability of the safety measure group’s loading factors. NJHA is concerned that continuing to use the current approach of denominator-based weights would only perpetuate the problems with star ratings.</p> | Jonathan Chebra,<br>Senior Director,<br>Federal Affairs, New<br>Jersey Hospital<br>Association | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | Balanced assessment. Star ratings performance should be based on performance across the breadth of available measures and not hinge disproportionately on one or two measures. As noted in the public comment document, the PSI measure and hip/knee complication measure have historically dominated the score of the safety measure group, even though the infection measures likely represent higher priority issues.  | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | <p>Confidence interval-based measure weights. MHA agrees with CMS that the weights applied to the measures used in the LVM 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 disproportionately weighted in the calculation of star ratings to such an extent that they drown out the effect of superior, well-validated quality measures. These suspect quality measures may do more harm than good. Based on the information available in the public comment document and communications we have had with experts in latent variable modeling, we believe the current approach “over-fits” the model and is methodologically flawed. We believe that by working with experts in latent variable modeling, it will be possible for CMS to develop a solution to this problem that is both mathematically correct and leads to a more rational approach for addressing measurement precision in star ratings, thereby improving the ratings accuracy, stability, and balance.</p> <p>In the star ratings LVM approach, CMS calculates a numerical “loading factor” for each star ratings measure. The higher a measure’s factor loading, the more it drives performance within a particular measure group. As the AHA and others have noted repeatedly, the loading factors within the patient safety measure group have fluctuated significantly, even though performance on the underlying measures has not changed appreciably. Furthermore, two measures in particular – the PSI composite measure and hip/knee complications – have a disproportionate influence on the safety score, even though the infection measures within the safety group arguably reflect more significant safety issues.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/29/2019   | Incorporating Measure Precision | <p>CMS asserts that at least some of the loading factor fluctuation and imbalance stem from the agency’s approach to dealing with measure precision. CMS’s current calculation of the LVM uses “denominator weights” in which hospitals are scored more heavily on measures that include larger numbers of patients. CMS offers three alternative approaches to this issue: confidence interval-based weights (in which the weights account for the confidence intervals of each measure’s calculation), logarithm of the denominator-based weights, and simply eliminating the denominator weights altogether.</p> <p>CMS indicates that its preference would be to use a combination of current denominator weights and logarithm of the denominator weights. However, the data in the public comment document show that the confidence-interval based weights best improve the LVM model fit for the safety group, as well as the balance and stability of the safety measure group’s loading factors. MHA is concerned that continuing to use the current approach of denominator-based weights would only perpetuate the problems with star ratings.</p> <p>Whatever other decisions are made about the calculation of the LVM, it must first be mathematically correct. We understand CMS and its contractor are trying to make it so, and we appreciate the staff’s diligent efforts. However, complex methodologies, like complex surgeries, require expertise to ensure correct execution. Fortunately, there are LVM experts at many colleges and universities. The AHA has shared the name of one such expert with CMS previously; we encourage CMS to reach out to the expert community.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a>             | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Confidence Interval Weighting (p 27) is supported as is log transformation of Safety group denominator (p28).  | Dale N. Schumacher, MD, MPH, President, Rockburn Institute  | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <p>CMS solicits feedback regarding the importance of including measure precision in Overall Hospital Quality Star Rating, as well as alternative approaches to including precision that will support more balanced contributions of measures within a group. We are concerned that evaluating different options for handling measure weight precision cannot be assessed due to the current instability in the LVM. This instability is related to how the measure weights are applied to the LVM calculation. The LVM calculation can be thought of as occurring in two steps, with Step 1 being an optimization function that refines the LVM parameters (i.e., factor loadings, error terms, and offsets) and Step 2 being a minimization function that calculates the LVM measure group scores for each hospital. The current implementation applies the measure weight adjustment to both steps of the LVM calculation. This can cause a measure to “overfit” the model, which results in that measure accounting for essentially all of the measure group score. As many stakeholders have observed, this has been occurring in the Safety of Care and Readmissions measure groups, with PSI-90 and Hospital Wide Readmissions dominating their respective measure groups.</p> <p>While removing the measure weights from the LVM would alleviate this issue, it is important to account for volume when deriving the Overall Hospital Quality Star Ratings. Isolating the application of the measure group weight to Step 2 of the LVM calculation largely resolves the LVM instability and corrects the “overfitting” issues that are occurring in the Safety of Care and Readmissions measure group. Further refinement of this approach is needed to ensure that it is truly a universal correction, or the measure weight adjustment will need to be applied outside of the LVM. Once this is corrected, a valid assessment of measure weight precision can be performed. Here, too, we agree with the AHA that whatever other decisions are made about the calculation of the LVM, it first must be mathematically correct – and again support ongoing engagement with subject matter experts to achieve this end.</p> | Peter M. Leibold,<br>Chief Advocacy<br>Officer, Ascension | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <p>Attempts at measure precision thus far (most recently the change to HAI measures using alternative denominator for weighting) did not have significant impact to create a more consistent model.</p> <p>Additional layers applied to this model do not address the overall problem that latent variable modeling is inappropriate for use with this data and should not be used for Star Ratings.</p> | <p>Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckely, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality &amp; Safety First Programs; VCU Health System</p> | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <p>Your examples suggest that one can obtain almost any loadings desired simply by changing the likelihood weights. This is suggested as well by equation (3), which you give in Section C.3. By changing likelihood weights you can turn on or off any measure you want from inclusion in calculating factor scores, recognizing of course that loadings depend on the likelihood weights. So it feels arbitrary to set them heuristically, or to manipulate them in order to achieve a desired result.</p> <p>You state on page 5, “For example, if a hospital only cares for 50 heart failure patients, but cares for thousands of pneumonia patients, the pneumonia measure would contribute more to that hospital’s group score.” It most likely would under this extreme example, but in real data I find that this effect is small (see also below under Peer Grouping). Table 6 of my paper shows that the under denominator weighting the amount of variation in group scores available to be captured by manipulating hospital-level weights in estimating group scores is quite small. Using December 2017 data, taking all weights equal to 1 (representing an “average” hospital) in estimating group scores gives an R2 of 0.999 for Readmission, 0.9999 for Safety of Care, 0.996 for Patient Experience, and 0.944 for Mortality.</p> <p>While the precise impact and significance of likelihood weights in the LVM approach, and how to best set them, is unclear, my proposed approach avoids this problem altogether. Denominator weights impact measure weights in a straightforward and an easy-to-understand manner. A measure that impacts three times as many patients as another is required to be weighted at least three times as much. My paper uses national volumes, but the approach can easily accommodate local hospital-specific volumes or some combination of the two.</p> | Dan Adelman,<br>Professor, University of Chicago Booth School of Business | <a href="mailto:Dan.Adelman@chicagobooth.edu">Dan.Adelman@chicagobooth.edu</a> | Individual            | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <p>Our users felt very strongly that facilities and consumers should have access to the volumes and quality as it relates to measures published or worked into the Overall Hospital Quality Star Rating. They also felt strongly that expected values (like in the case of SIR) should not be used in the weighting scheme. They offered no other means to weight or provide reliability of the measure. See pages 18 and 19 in the original request. There is concern that hospitals may be incentivized to game the system. Additionally, there is a low volume vs. high volume risk. However, with the exception of one executive, we agree with the basic idea of incorporating improvement into the overall score, and would need to see specifics on qualitative evaluation beyond what is given.</p> <p>See page 21 in the original request. We agree that too much emphasis has been placed on the PSI 90 metric and would like to see the sub measures used and broken into a new group.</p> <p>See pages 28 - 29 with Table 12 in the original request. We would benefit form greater unifor- mity across the board, but we understand weighting by volume to affect the overall score is how things should be done. Our preference in weighting schemes is</p> <ul style="list-style-type: none"> <li>. No Weighting</li> <li>. Denominator Weighting</li> <li>. Log Weighting</li> <li>. Confidence Interval Weighting</li> </ul> | Joshua Fetbrandt,<br>Quality Analyst, Tahoe Forest Health System | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Incorporating Measure Precision | <ul style="list-style-type: none"> <li>• We would not support keeping the current practice of using the measure’s denominator to precision weight. The methodology is too complicated for hospitals or consumers to understand and its complexity does not add value to the overall of the tool or the result. It also contributes to the por balance of measures in the Safety of Care group. This weighting has rendered certain measures (HAIs) meaningless, while others (PSI-90) are completely driving the entire score of the group.</li> <li>• The log transformation weighting was considerably more balanced than the current weighting.</li> <li>• The confidence interval weighting seemed the most balanced of all of the options.</li> <li>• We have no issues with applying a change to only certain measure groups. Specifically, Safety of Care needs to be adjusted. If it is deemed that the other groups are fine as they are, and we do not have a concern using different weighting methods among groups.</li> <li>• I think the options given provide potential solutions.</li> </ul> | Jean Cherry, FACHE, Executive Vice President, Med Center Health                           | <a href="mailto:jean.cherry@mchealth.net">jean.cherry@mchealth.net</a>           | Healthcare System                          | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | <p>Questions</p> <p>a. Do you have any concerns about changing the methodology to use a combination of denominator weighting and log (denominator) weighting, based on the type of measure?</p> <p>b. Do you have any concerns about applying a change to the weighting approach across all measure groups (where data are available) vs. applying the change only to measure groups that meet specific criteria?</p> <p>c. Are there other approaches that CMS should consider?</p> <p>Comments</p> <ul style="list-style-type: none"> <li>• Support</li> </ul>   | Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center | <a href="mailto:deede.wang@vumc.org">deede.wang@vumc.org</a>                     | Medical University                         | Please refer to the Summary Report |
| 3/29/2019   | Incorporating Measure Precision | Vizient believes measure precision choices limited Star Rating result accuracy given the latent variable modeling challenges we identified. While Vizient acknowledges that measure precision can be improved by incorporating increased denominator weighting or applying various weighting approaches, this change may not be effective in improving the latent variable modeling accuracy or fit. In turn, Vizient recommends exploring a more explicit measure weighting approach and discontinue latent variable model derived measure weighting.   | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.  | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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|-------------|---------------------------------|--|---|--|---|------------------------------------|
| 3/29/19     | Incorporating Measure Precision | The scaling method should be applied consistently across all measure denominators despite differences in magnitude and kurtosis to best account for reliability of a measure. Premier recommends a natural-log based scaling approach across measures as it remains mathematically valid and reduces measure-specific complexity in the program. Additionally, CMS should consider normalizing the log-transformed denominators with min/max scaling. Log-transformed-denominators will greatly reduce magnitudinal differences across measures; however, a natural bias toward procedure-based HAI measures and high-volume cohorts will continue to occur. Such bias can be further mitigated with the application of min/max scaling—a method to scale a vector between 0 and 1. In the event that measures with denominators of zero are included in the calculation, a value of 1 added to all denominators is common practice to prevent errors resulting from a log of zero (i.e. infinity).                  | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance                                       | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | CMS is considering changing the weighting options that account for differences in measure score precision across hospitals. The current methodology uses denominator weighting. This methodology has contributed to imbalances in the loadings, causing some measures to be more heavily weighted than others to the detriment of the consideration of hospital performance on the overall star rating. If CMS continues with the current methodology, applying log transformations in the denominators provides a more equitable distribution of loadings. However, this approach, while methodologically preferable in this context, is not intuitive and will be difficult to explain to stakeholders. The FAH cautions against using a mixed weighting methodology across the different measures and urges CMS and its contractor to evaluate thoroughly the impact of any change in methodology it is proposing and to share that information with stakeholders for review and comment prior to implementation. | Chip Kahn, President, CEO, Federation of American Hospitals   | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a>                       | Hospital Association                            | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | APIC believes that the proposed use of volume rather than NHSN-predicted data in measure calculations raises the known, ongoing concern for accuracy in retrieving data such as devices days/patient days/procedures within the electronic medical record (EMR), or even manually, for those organizations without EMRs.   | Karen Hoffmann, RN, MS, CIC, FSHEA, FAPIC, President; Association for Professionals in Infection Control and Epidemiology | <a href="mailto:nhailpern@apic.org">nhailpern@apic.org</a>                     | Professional Association                        | Please refer to the Summary Report |

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| 3/29/19     | Incorporating Measure Precision | We applaud CMS for taking into consideration how each measure's and hospital's scores precision are weighted within the Latent Variable Model method currently being used. PSI-90 is given disproportionate weight. We believe that CMS should continue to analyze and understand approaches to improving the incorporation of measure precision in the ratings, and use the method that balances weights of the measures in a group. Given analysis done by CMS, we strongly recommend the confidence interval method to be used.   | George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health | <a href="mailto:George.t.blike@hitchock.org">George.t.blike@hitchock.org</a>         | Healthcare System     | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | AHPA believes that while none of the proposed weighting approaches completely address CMS' concern, log transformation of the denominator would be the most mathematically appropriate approach. Log transformation helps with normalization of the data anytime there are outliers or skewness. Other transformation methods should also be explored, depending on the distribution of a measure. Square-root and inverses or any Box-Cox transformation would likely remove skewness in the distribution. Additionally, other model performance statistics should be calculated for proper evaluation.<br>AHPA also recommends using the confidence interval weighting as an alternative that could be applied to all the risk-adjusted measures (Readmission, Mortality, Safety). Box-Cox transformations could be used for the non-risk adjusted measures to remove any non-gaussian attributes.<br>AHPA believes that the weighting approach should be applied to measure groups that are not balanced or consistent. | Carlyle Walton, FACHE, President; Adventist Health Policy Association   | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System     | Please refer to the Summary Report |



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| 3/29/19     | Incorporating Measure Precision | <p>We are concerned by the findings of Tables 10 and 11. Denominator weighting sounds like a reasonable means of incorporating precision into the ratings system. However, the confidence interval weighting scheme, as well as the log transformation scheme, also seem theoretically reasonable. Without some specific methodological or statistical reason to prefer one over the other, the fact that they produce radically different loadings further calls into question the validity of the LVM approach altogether. Indeed, when an apparently arbitrary modelling decision yields very different results, we should be very concerned whether the output of the system actually reflects what it purports to. Results should not reflect the choice of methodology more than the healthcare reality on the ground.</p> <p>We also note that Table 10's column "Denominator Weighting (Current) July 2018" appears to contradict the attached "StarRatingsJul18_UpdtSpecsRpt.pdf" p21.</p> | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                                     | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Incorporating Measure Precision | <p>In the shorter-term I believe the log transformation of the denominator weighting option is preferable based on the results presented; even though it's not intuitive, neither is the current method so at least the log method has the benefit of improved consistency/distribution of weights for skewed denominators.</p> <p>In the longer term, having all measures with equal weights feels the most intuitive, even if it means that measures with small denominators (i.e, less stable/more variable measures) count the same as measures with larger denominators (i.e., more stable/less variable measures). A minimum denominator would need to be established to ensure some level of stability however.</p>  | Laura Morris, MS, CPHQ, Senior Business Analyst for Quality  | <a href="mailto:lmorris@glensfalls.hosp.org">lmorris@glensfalls.hosp.org</a>               | Individual             | Please refer to the Summary Report |
| 3/6/2019    | Period to Period Shifts         | No more than 2 rating periods each year   | Patricia D. Boyette, MSHS, BSN, NE-BC Director, Operational Performance Improvement Corporate Quality, Orlando Health                          | <a href="mailto:Patricia.Boyette@orlandohealth.com">Patricia.Boyette@orlandohealth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/11/2019   | Period to Period Shifts | I would support refreshing the Overall Star Rating once a year to allow for changes in measure-level data and measure periods with incomplete data and the effects of those on star ratings.   | Rhonda Unruh, MHA, RN, CIC, Vice President of Quality, Guadalupe Regional Medical Center  | <a href="mailto:runruh@grmedcenter.com">runruh@grmedcenter.com</a>         | Individual            | Please refer to the Summary Report |
| 3/14/2019   | Period to Period Shifts | <ul style="list-style-type: none"> <li>What are possible benefits and drawbacks to increasing stability by limiting change in this way?</li> </ul> <p>HFHS is not overly concerned about shifts in rating from one period to another, except in unusual situations where a shift of two levels or more is clearly being driven by random fluctuation rather than true improvement or backsliding in quality. As noted in the Request document, some movement is both expected and desirable.</p> <ul style="list-style-type: none"> <li>Should the Overall Hospital Quality Star Rating methodology be modified to incorporate data from previous periods through a time averaged approach?</li> </ul> <p>HFHS agrees with the previous Technical Expert Panel (TEP) and stakeholder groups that inclusion of information from previous time periods to enhance stability is not a good idea. We agree with those groups that the information included in the Star Rating system should be the most recent data available.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System                                    | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a>                         | Health System         | Please refer to the Summary Report |
| 3/15/2019   | Period to Period Shifts | <ul style="list-style-type: none"> <li>STAR ratings only once per year? Twice a year overall STAR ratings is a nice way to update the data.</li> </ul>   | Kathy J. Nunemacher MSN, RN, CPN, CPHQ St. Luke's University Health Network Network Director Clinical Quality Data Governance and Reporting | <a href="mailto:Kathy.Nunemacher@sluhn.org">Kathy.Nunemacher@sluhn.org</a> | Individual            | Please refer to the Summary Report |

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| 3/19/2019   | Period to Period Shifts | <b>1.Change in Reporting Schedule:</b> updating the Overall Hospital Quality Star Rating reporting schedule so that ratings are refreshed once annually, rather than biannually. We at Lee Health wanted to recommend keeping a biannual refresh as to maintain alignment with more frequent updates in HAI (Safety) and HCAHP (Patient Experience) data. The nature of PSI-90, Readmissions and Mortality all updating in July and collectively influence the overall score more is valid, but this could diminish incremental improvements in the aforementioned areas.   | Raymond Pugh, Clinical Optimization Specialist II, Lee Health   | <a href="mailto:raymond.pugh@leehealth.org">raymond.pugh@leehealth.org</a>                     | Health System         | Please refer to the Summary Report |
| 3/20/2019   | Period to Period Shifts | Participants were not supportive of annual reporting. They said that it is important that consumers be given the most relevant and timely information. They said the CMS Compare site is a trusted resource and knowing that the information is the most current available is part of that trust.   | Leadership, Oregon State Health Insurance Assistance Program (SHIP)/Senior Health Insurance Benefits Assistance (SHIBA) | Forwarded by CMS leadership  | Purchaser             | Please refer to the Summary Report |
| 3/21/2019   | Period to Period Shifts | <ul style="list-style-type: none"> <li>What are possible benefits and drawbacks to increasing stability by limiting change in this way?</li> </ul> <p>The only benefit would be less change in ratings. Drawbacks include having ratings that are based on very old data, taking much longer to see the impact of improvement, and the added calculation steps that make it harder to analyze scores and identify opportunities for improvement.</p> <ul style="list-style-type: none"> <li>Should the Overall Hospital Quality Star Rating methodology be modified to incorporate data from previous periods through a time averages approach?</li> </ul> <p>No. The data used is already old enough. Star ratings are used by consumers to make healthcare decisions in the current timeframe. Using old data or slowing the change in ratings could be misleading. Using old data also makes it difficult to see how improvement activities are affecting the facilities ratings. This makes it difficult for front line staff and providers to see the benefits of their hard work.</p> | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health                                    | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System         | Please refer to the Summary Report |

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| 3/21/2019   | Period to Period Shifts | “CMS is seeking public input on an annual Overall Hospital Quality Star Rating publication schedule.” Though it is well intentioned to update the star ratings on a biannual basis risk adjusted quality measures make up a significant portion of the star rating and are only calculated once a year. An annual release of star ratings makes sense. If these risk adjusted measures could be updated more frequently we would welcome a biannual update of the star ratings to better reflect improvement projects ongoing within our facilities.                 | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health                               | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System          | Please refer to the Summary Report |
| 3/21/2019   | Period to Period Shifts | One significant improvement I would like to see: an earlier reward for major efforts to improve.<br>Right now collection periods are long and reports are so delayed that major efforts to improve can take 1 – 2 years to show up in the data.<br>It would be wonderful if somehow the reports could reflect positive changes that might occur in the last 6 months of a 2 year collection period.<br>Right now “Reward” for major efforts to improve don’t get shared with the hospital (or the public) for too long. It really reduces the incentives for trying. | David Raymond, MPH, President, Clinical Financial Management Associates, LLC                                       | <a href="mailto:draymond@clinicalfinancial.com">draymond@clinicalfinancial.com</a>             | Individual             | Please refer to the Summary Report |
| 3/22/2019   | Period to Period Shifts | WHA supports refreshing star ratings annually, which should decrease shifts, allow CMS to test and validate data results, and provide time for continuous stakeholder input and feedback.  | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital                              | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a>                                   | Hospital               | Please refer to the Summary Report |
| 3/22/2019   | Period to Period Shifts | We agree with CMS' concerns that large ratings shifts within 6 months suggest that the methodology, not the care, is driving the results. Overall, refreshing of results based on a reliable methodology twice a year would be superior for patients. We suggest CMS incorporate the refinement to the methodology from these public comments prior to an increased frequency of reporting.  | Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University | <a href="mailto:bruce.meyer@jefferson.edu">bruce.meyer@jefferson.edu</a>                       | Health System          | Please refer to the Summary Report |

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| 3/25/2019   | Period to Period Shifts | <p>Benefis Health System’s primary recommendations regarding the Star Rating system include the following: Recommendation #1 – CMS should improve the predictability and accuracy of the Star Rating methodology. The current Star Rating methodology is overly sensitive to subtle data changes and unfairly adjusts the data reported by mid-sized hospitals such as Benefis. While Benefis constantly strives to provide excellent care across the board, it is also imperative that we understand which outcomes CMS deems most important in order to prioritize our key focus areas. However, the current methodology results in Benefis experiencing rating changes uncorrelated to performance changes and seemingly uncorrelated to peer performance changes.</p> <p>In the July 2018 Star Rating report, Benefis was considered to be performing at a level above the national average in the Safety of Care measure group. By the subsequent February 2019 update, Benefis had been re-designated as performing below the national average despite our performance in the individual categories that form the aggregate Safety of Care score remaining statistically stable. This wide variation was only due to a change the weighting of individual measures within the measure group yet was completely unpredictable in advance of the ratings being published because it was driven by methodology that determines the weight of individual metrics after data is inputted. These changes have major implications on our overall Star Rating, with the Safety of Care measure group constituting 22% of our aggregate score. As such, the changes should be driven by active decisions on the part of CMS to change the weights, and those decisions should be finalized and communicated in time for hospitals to adjust their practices accordingly prior to results being reported.</p> | Greg Tierney, MD,<br>Chief Medical Officer<br>and Medical Group<br>President, Benefis<br>Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |

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| 3/25/2019   | Period to Period Shifts | <p>CMS should approach measure grouping and measure precision with a focus on utilizing criterion that ensure that measure loadings are reasonably balanced within periods and reasonably consistent between periods, resulting in better predictability for future periods.</p> <p>The current latent value methodology (LVM) is overly sensitive to subtle changes in the underlying data. Though BHS strives to improve care and outcomes across the board, it is also imperative that we know and focus our efforts and limited resources on outcome improvements that have been deemed most important to CMS. The current methodology has lost face value with our BHS leadership and Board of Directors. As an example, with the current LVM methodology (February 2019 Compare Update) and within one measures group (Safety of Care), BHS is rated as “same as the nation” in all individual measures, yet as “below the nation” as the overall rating for that measures group. This wide and unpredictable variation was only due to the determination to change the weightings of the individual measures within the measures group (LVM), and not because of any statistical change in our actual quality outcomes. The bottom line is that utilizing the LVM results in vast unpredictability and results that are nearly impossible to explain.</p> | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |
| 3/25/2019   | Period to Period Shifts | In regards to period to period shifts, perhaps an overall improved methodology will result in more predictable shifts. Data reported on CMS Compare and subsequently used to calculate the Overall Star Rating is already quite retrospective. Limiting the refreshing of the Overall Star Rating to once a year would again decrease face validity to hospitals and consumers, as the published Star Rating would not coincide with the exact data and outcomes reported alongside on the Compare website. The data on the Compare website should closely correlate with the data that was used to calculate the published Overall Star Rating. Overall, we support methodology changes that establish balance and predictability between reporting periods so that we are able to best focus our resources on improving actual quality outcomes. Outcomes and measures group scores should be based on actual versus predicted data, and not on the adjustments within a math equation, such as what occurs with the current latent value methodology.   | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |

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| 3/26/2019   | Period to Period Shifts | -Method changes: It is imperative that CMS stop releasing a method that is not fully vetted and consistent. CMS is doing everyone a disservice. Eliminate the star report altogether for a year or more until there will no longer be any more significant changes.   | Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital   Quality Management Dept. | <a href="mailto:scrimet@amc.edu">scrimet@amc.edu</a>             | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Period to Period Shifts | <ul style="list-style-type: none"> <li>• <b>Period-to Period Shifts:</b> WHA supports refreshing star ratings annually, which should decrease shifts, allow CMS to test and validate data results, and provide time for continuous stakeholder input and feedback.</li> </ul>   | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association  | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>           | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Period to Period Shifts | <p>For the CMS star rating to be truly customer facing and useful, CMS also needs to commit to a regular and consistent timeframe of release of the ratings as well as highlighting what the measure performance time period is. Reliability and consistency are key components to effective measures and ratings as is ensuring that the ratings are as accurate as possible rather than being held to a 2017 rating for the entirety of 2018 as occurred last year. This is of particular importance as CMS weighs options for change in future star rating methodologies.</p> <p>Patients, as consumers, should be made to understand that the data used in the ratings lags current performance periods and so the rating is based on a historical perspective rather than a current or prospective one that might indicate an improvement or worsening of rating.</p> <p>Thank you for considering new and innovative options for how we can all move towards a better understanding and demonstration of both quality and value as it exists in healthcare and how this can be best showcased to the public at large.</p> | Daniel J. Baker, MD, MBA, Medical Director, Lenox Hill Hospital  | <a href="mailto:djbaker@northwell.edu">djbaker@northwell.edu</a> | Individual             | Please refer to the Summary Report |



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| 3/27/2019   | Period to Period Shifts | <p>Reducing Frequency of Star Ratings Methodology Refresh</p> <p>We appreciate CMS's interest in reducing the number of times per year the Star Ratings process is refreshed. Stakeholders have expressed concern that large shifts in the rating can be observed over a six-month period, and that it can be difficult to explain changes in the rating despite observing relatively modest changes in a hospital's performance on individual measures. UC Health sees benefit in providing an annual refresh schedule for the Overall Hospital Star Rating versus a biannual refresh. This would have the benefit of allowing for a change in a hospital's rating to be more clearly attributed to observed changes in the hospital's performance for the underlying measures.</p> <p>In addition to addressing the frequency of a Star Rating refresh, CMS needs to make the data collected more relevant to consumers. Much of the quantitative data that feeds into the Star Rating are two years in arrears. It would be more reflective of the evaluated hospitals' current statuses if more contemporaneous data was applied to derive hospitals' Star Rating (i.e., data no older than 6 months).</p>   | John Stobo, MD, Executive Vice President, University of California Health System           | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a>                     | Health System          | Please refer to the Summary Report |
| 3/27/2019   | Period to Period Shift  | <p>Period to Period Shifts: CMS would like feedback from the public regarding the benefits and drawbacks of refreshing the Overall Hospital Quality Star Rating only once a year.</p> <p>We appreciate that CMS is requesting feedback on the reporting period for the star ratings. We support CMS moving to annual reporting to align with other current CMS reporting updates on hospital compare. In addition, we believe the instability of the star ratings between each 6 month reporting period can be even more confusing for the target audience especially when they do not understand the methodology behind the ratings. It will be difficult for the general public to understand why for example, a particular hospital dropped from 3 stars to 2 stars in a six month period. While there may be some apprehension to extend the reporting period to one year because a hospital could show improvement in six months, annually will be more consistent given the retrospective time period used for the star ratings We believe the results should demonstrate more consistency for the intended target audience and that most healthcare organizations like ours are already tracking these measures on a monthly basis for improvement.</p> | Angela A. Shippy, MD, FACP, FHM SVP & Chief Quality Officer Memorial Hermann Health System | <a href="mailto:Angela.Shippy@memorialhermann.org">Angela.Shippy@memorialhermann.org</a> | Health System          | Please refer to the Summary Report |



| Date Posted | Measure Set or Measure     | Text of Comment  | Name, Credentials, and Organization of Commenter                     | Email Address*   | Type of Organization *  | Response*                             |
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| 3/27/2019   | Period-to-Period Shifts    | MHA appreciates the chance to comment on this potential update and agree with other stakeholders that the limited benefit of the proposed approach is overshadowed by the need for current data and easily could confuse and mislead consumers. We believe that large period-to-period shifts in Star Ratings arising as a function of changes to constituent measures, in large part, likely are a function of highly imbalanced measure weights and loadings that would be better addressed in other ways, including those depicted in potential updates and comments provided in sections 4.1, 4.2 and 4.3. In the current Star Ratings methodology, the effect of measurement changes is difficult to assess in advance by measure developers and hospital stakeholders due to the complexity of the analytic methods used. The confusion and explanatory challenges for providers and consumers that arise from not being able to easily trace the cause of a sudden, substantive change in ratings without a discernable change in performance is one of several reasons MHA believes that all stakeholders would benefit from a fundamental rethinking of the Star Ratings methodology in a manner that favors greater transparency in lieu of methodologic elegance. | Herb B. Kuhn,<br>President, CEO,<br>Missouri Hospital<br>Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a>                       | Hospital<br>Association | Please refer to the<br>Summary Report |
| 3/27/2019   | Period to<br>Period Shifts | <b>The Challenge</b><br>The goal of the Overall Hospital Quality Star Rating is to improve the usability, accessibility, and interpretability of CMS' hospital quality website, Hospital Compare, for patients and consumers. As things stand, the rating relies on a latent variable modeling approach, in which weights are assigned by the model itself to the different measures which are taken into account in the rating. Many hospitals have found that this modeling approach produces results that are neither very reliable nor easily reproducible. This leads to unstable hospital ratings that can change substantially over measurement periods - some hospitals experience a swing of two or three stars from year to year, out of a total of five. Cook County Health endorses a number of proposed approaches to improve the Overall Star Rating methodology, which are outlined below:  | John Jay Shannon,<br>CEO, Cook County<br>Health                      | <a href="mailto:joshua.mark@cookcountyhhs.org">joshua.mark@cookcountyhhs.org</a> | Health<br>System        | Please refer to the<br>Summary Report |

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| 3/28/2019   | Period-to-Period Shifts | <ul style="list-style-type: none"><li>Period-to-Period Star Rating Shifts: The AAMC supports the proposal to move to an annual update cycle, until there are further improvements in the reliability and stability of the methodology, and further exploration of “partial-star” Overall Hospital Ratings. We believe the drawbacks outweigh the possible benefits of incorporating weighted averages to address period-to-period shifts.</li></ul> <p>Period-to-Period Star Rating Shifts</p> <p>In response to the substantial shifts in ratings observed in the unpublished July 2018 release, CMS has undertaken analysis of options to stabilize period-to-period shifts in the ratings. From this, CMS seeks feedback on the following potential improvements: (1) use of a weighted average summary score, (2) use of “partial” Star Ratings, and (3) moving to an annual refresh schedule. Shifts in ratings observed from measurement period to measurement period cause the ratings to appear random, and thus are difficult for hospitals to use for performance improvement activities. The AAMC remains concerned about these shifts, and our comments to each of CMS’s potential improvements are below.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Period-to-Period Shifts | <p>Incorporating data from an older period, especially at higher weights, would drastically reduce shifts of two or more stars. The drawback to such an approach is that it would limit the timeliness and currency of data available to patients and consumers and delay a hospital's realization of improvement in the ratings relative to improvement observed on the underlying measures. The AAMC believes the drawbacks outweigh the possible benefits, and does not support the incorporation of a weighted average to address period-to-period shifts.</p> <p>An alternative to use of a weighted average is the incorporation of "partial" or "half" Star Ratings, such as 2.5 stars or 3.5 stars, as this would reduce the "cliffs" between hospital categories (i.e., the actual difference in scores between a "high" 2-star and a "low" 3-star hospital) and provide greater clarity to patients and consumers on a hospital's relative performance. Additionally, the Agency's Home Health Compare Star Ratings for home health agencies and the Medicare Advantage Plan Quality Star Ratings programs utilize half-star ratings, suggesting that similar methodologies for use of half-stars might be easier to implement. The AAMC supports further exploration of "partial" Star Ratings, as we agree that it may be an appropriate alternative option to reduce period-to- period shifts.</p> <p>Finally, CMS seeks comment on whether it should move to an annual update cycle for the Overall Hospital Quality Star Rating, essentially tying the timing of the ratings cycle to measures that are refreshed annually (which include most of the underlying outcomes measures: PSI-90, hip/knee complications, EDAC measures, readmissions measures, and mortality measures). Stakeholders have previously expressed concern that the current biannual ratings update is not aligned with annual measure refreshes, and may result in changes in rating for hospitals near cutoffs due to sensitivity to modest changes to measures outside the major annual refresh schedule. Given the current issues and concerns with the methodology, moving to an annual refresh schedule would smooth period-to- period shifts and provide greater predictability in the release schedule. The AAMC supports the proposed move to an annual schedule for the Overall Quality Star Ratings until there are further improvements in the reliability and stability of the methodology.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.org">galee@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Period to Period Shifts | Also, we recommend that when major adjustments have been accomplished, reporting should be updated annually.   | Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital<br>Henry Pitt, MD, Chief Quality Officer, Temple University Health System | <a href="mailto:henry.pitt@tuhs.temple.edu">henry.pitt@tuhs.temple.edu</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Period to Period Shifts | It could be beneficial if the star rating was provided annually.   | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center   | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a>                   | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Period to Period Shifts | The rating system should be established into a top decile and top quartile scoring process for achievement thresholds. An annual release would also need to use standardized metrics which are changing with every recent release (i.e., 64 metrics and changed to 54 metrics).  | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center   | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a>                   | Health System          | Please refer to the Summary Report |
| 3/28/19     | Period to Period Shifts | As the co-efficients change, hospitals find it challenging to know where to focus. While we want to provide the best possible care in all areas, it is helpful to know how we are going to be evaluated in time to address any issues. We would suggest a transition period for any significant changes to the star rating system to give hospitals time to make adjustments if needed. We would also ask that after the comment period and any subsequent revisions, CMS would compile a guide for hospitals on how to help them understand the ratings and know where to target improvement. | Donald E. Williamson, MD, President/CEO; Alabama Hospital Association   | <a href="mailto:rblackmon@alaha.org">rblackmon@alaha.org</a>               | Hospital Association   | Please refer to the Summary Report |

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| 3/28/19     | Period to Period Shifts | <p><b>4.4 Period-to-Period Star Rating shifts Questions for the Public</b></p> <p>What are possible benefits and drawbacks to increasing stability by limiting change in this way? <b>Refreshing the data on an annual basis is preferable to updating every 6 months, assuming that the model uses current data, appropriate metrics, and is explicit in nature. This question cannot be answered well until the foundational question of the appropriate model has been addressed.</b></p> <p>Should the Overall Hospital Quality Star Rating methodology be modified to incorporate data from previous periods through a time averaged approach? <b>No, prefer to use most current data</b></p> <p>Are there other approaches to this CMS should consider? <b>Once data is more reliable and reproducible, updating the data on a more frequent basis could provide value to patients and to the hospitals in their performance improvement efforts.</b></p> | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System         | Please refer to the Summary Report |

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| 3/28/19     | Period to Period Shifts | <p>Reviewing consistency over time is required. The significant switch in loading during the June 2018 release from PSI-90 to THA/TKA complication created significant, unanticipated swings in domain and overall scores. The following table <a href="#">[Table 11]</a> shows the change in loadings over time and the shift during the June 2018 (un)release.</p> <p>This nuance makes it hard for hospitals and consumers to understand why ratings are so variable. Additionally, every hospital wants to do well in these measures and every hospital is constrained by limited resources. Having less variable swings in weighting of measures helps hospitals prioritize improvement activity vs jumping to the new thing.</p> | <p>Dr. Omar Lateef<br/>Stuart Levin, MD<br/>Presidential Professor of Rush University<br/>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br/>Rush University Medical Center<br/>Chicago, Illinois<br/>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine<br/>Thomas A. Webb, MBA Manager, Quality mprovement; Rush University Medical Center</p> | <p><a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a></p> | Medical University    | Please refer to the Summary Report |

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| 3/28/19     | Period to Period Shifts | <p>We agree with the recommendation for only releasing once a year. It is currently confusing with the multiple releases where some measurement periods stay the same (mortality, readmissions) and some domains shift measurement periods (patient experience, HAIs).</p> <p>We do not agree with combining data from prior reporting periods because these end up creating even longer measurement periods. Many of the mortality and readmission measures with a three year measurement period are already too long. Incorporating older data will make it even worse. The ability to improve on the score is much harder and reduces incentives for hospitals to actually improve.</p> | <p>Dr. Omar Lateef<br/>Stuart Levin, MD<br/>Presidential Professor of Rush University<br/>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br/>Rush University Medical Center<br/>Chicago, Illinois</p> <p>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine</p> <p>Thomas A. Webb, MBA<br/>Manager, Quality Improvement; Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University    | Please refer to the Summary Report |

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| 3/29/2019   | Period-to-Period Shifts | <p>Some stakeholders have expressed concern about larger-than-expected shifts in ratings from December 2017 public reporting to July 2018 confidential reporting, despite no updates to the methodology. It is important to note that some shifts in the Overall Hospital Quality Star Ratings are expected, as measure-level data and hospital-level performance change. In response, CMS looked into ways to temper the magnitude of shifts in the Overall Hospital Quality Star Ratings. One approach CMS is considering is a transition to reporting the Overall Hospital Quality Star Ratings once a year, rather than twice (as currently), so that changes in hospital ratings are more predictable based on changes in underlying measures. Spectrum Health opposes moving to one per year, and would prefer as often as possible. The sooner we are aware of shifts in performance, the better we are able to make changes when it matters.</p> <p>Further, we do not recommend CMS do anything to limit the shifts, as these shifts can be reflective of other factors that need to be evaluated and possibly addressed.</p> | Leslie M. Jurecko MD, MBA<br>SVP, Quality, Safety, and Experience<br>Spectrum Health<br>Pediatric Hospitalist<br>Assistant Professor of Pediatrics at Michigan State University, College of Human Medicine | <a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a>     | Hospital               | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | <b>3. Period-to-Period Star Rating Shifts:</b> While Advocate Aurora supports the proposal to move to an annual update cycle and further exploration of “partial-star” Overall Hospital Ratings, CMS must further review the causes of the significant shifts that have occurred in recent updates to fully comprehend methodological impacts on the scores.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health   | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a>   | Health System          | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | While reducing the refreshing of star ratings to once per year may smooth out rating shifts, CMS must further review the causes of the significant shifts that have occurred in recent updates, to fully comprehend methodological impacts on the scores, and determine whether further adjustments to the methodology are warranted.  | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer;<br>Advocate Aurora Health   | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a>   | Health System          | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | We believe the latent variable modeling (LVM) strategy utilized in establishing the rating is unstable and unreliable, as it allows the model to dynamically determine the outcome based on latent variable input leading to different result each time the data is produced. This inconsistent reporting based on latent or unknown factors makes it difficult for the organization to focus on areas for quality improvement.  | George V. Masi,<br>President and CEO;<br>Harris Health System  | <a href="mailto:Elizabeth.Greenlee@harrishealth.org">Elizabeth.Greenlee@harrishealth.org</a> | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Period to Period Shifts | 3. <u>Period-to-period shifts</u> . CMS asks for recommendations to temper the large shifts some hospitals experience in star ratings with each update. We believe that this issue would be alleviated based on a pre- defined measure weighting system, as discussed above. Related to this matter, <b>we would advocate for an annual refresh rather than the current bi-annual update since some of the measure groups, such as the readmission and mortality measures are currently only updated annually on Hospital Compare.</b>   | Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic                          | <a href="mailto:deylingc@ccf.org">deylingc@ccf.org</a>   | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Frequency of Refreshing the Star Ratings: We support the current practice of refreshing the Overall Quality Hospital Star Ratings two times a year. This approach could allow for the most recent data to be used in calculating a hospital's rating. This timeliness is important to both patients seeking information about healthcare quality and to the hospitals being rated.   | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a>   | Health Organization    | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Stakeholders expressed concerns regarding more substantial shifts in ratings and CMS chose to evaluate methods that could make the Overall Hospital Quality Star Ratings more stable between refreshes.<br>HANYS opposes CMS' proposal to blend hospital ratings with historical star rating results, as this leads to even more historical data used in the star ratings — a common complaint from hospitals seeking to improve on the star ratings in real time.<br>HANYS urges CMS to implement other, more meaningful changes to its methodology to ensure modeling is accurate and less sensitive to data updates over time, such as the shift to confidence interval weighting described above or the removal of the PSI-90 composite measure in the lopsided safety of care domain. | Marie Grause, RN, JD, President, Healthcare Association of New York State                         | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | To provide consumers with the timeliest information as prioritized by the Patient & Patient Advocate Work Group, UPH supports the current biannual refresh schedule. Although we understand the advantage of ensuring that every measure refreshes before calculating each Star Rating as envisioned in an annual refresh, other Star Ratings systems such as Nursing Home Compare refresh on a more frequent quarterly basis. Significant cyclical ratings fluctuations would seem to indicate issues with the overall Star Ratings system and should not be addressed by delaying public data reporting. | Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health<br>Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a>             | Hospital  | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Agree with recommendation to use the most recent data. Could this apply to mortality and readmission data? Both use data starting in July 2014 – almost 5 years old. This is not representative of the care that we provide today.   | Larry Mandelkehr, Executive Director, Hospital Quality and Innovation, UNC Health Care System  | <a href="mailto:Larry.Mandelkehr@unchealth.unc.edu">Larry.Mandelkehr@unchealth.unc.edu</a> | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Another concern we've had with the star rating system is the stability of the reporting. The star rating wasn't updated for nearly 1 ½ years due to concerns of the scoring methodology. This gave consumers shopping for healthcare providers inaccurate information of a facility during that time frame. Hospitals saw major changes of measure retirement and additions during this timeframe as well which could have affected the overall scoring of a facility.   | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality   | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a>                         | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Disagree with combining multiple periods to reduce shifts. The data periods vary across measures and groups, and are already quite outdated in some instances. It is difficult to communicate internally the need for change on data that can be 2.5+ years old. The previous proposed changes may reduce the shifts, and thus making this proposal even less attractive. Perhaps publish (1) prior and current star ratings?  | Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health  | <a href="mailto:kathleencarrothers@gmail.com">kathleencarrothers@gmail.com</a>             | Individual                                      | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | RWHC would be in favor of Star rating updates only once a year rather than twice a year. Because small rural hospitals have smaller populations a poor score in 1 quarter could show a bigger negative change on bi-annual updates rather than changes to scores over the longer period of a year.   | Tim Size, Executive Director, Rural Wisconsin Health Cooperative   | <a href="mailto:JLevin@rwhc.com">JLevin@rwhc.com</a>                                       | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>DHR appreciates CMS' thoughts on tempering larger than expected shifts in hospitals' star-ratings based on Hospital Compare's publication schedule. In this Public Input Request, CMS expressed interest and requested public comment on updating the Overall Hospital Quality Star Rating to only once per year, as opposed to the current biannual update schedule.</p> <p>DHR urges CMS to continue their biannual update schedule for Hospital Compare. DHR acknowledges that a biannual update may result in larger-than-expected shifts in ratings, however, a continued biannual schedule also allows hospitals to improve their score more than just once a year and thereby provide patients with the most accurate and up to date ratings. OHR urges CMS to keep their biannual update schedule for Hospital Compare.</p>   | Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health                                  | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>PCMS seeks feedback on the following potential improvements: (1) use of a weighted average summary score, (2) use of "partial" Star Ratings, and (3) moving to an annual refresh schedule. Shifts in ratings observed from measurement period to measurement period cause the ratings to appear random, and thus are difficult for hospitals to use for performance improvement activities. Incorporating data from an older period, especially at higher weights, would drastically reduce shifts of two or more stars. The drawback to such an approach is that it would limit the timeliness and currency of data available to patients and consumers and delay a hospital's realization of improvement in the ratings relative to improvement observed on the underlying measures. LVHN believes the drawbacks outweigh the possible benefits, and does not support the incorporation of a weighted average to address period-to-period shifts.</p> <p>An alternative to use of a weighted average is the incorporation of "partial" or "half" Star Ratings, such as 2.5 stars or 3.5 stars, as this would reduce the "cliffs" between hospital categories (i.e., the actual difference in scores between a "high" 2-star and a "low" 3-star hospital) and provide greater clarity to patients and consumers on a hospital's relative performance. LVHN supports further exploration of "partial" Star Ratings, as we agree that it may be an appropriate alternative option to reduce period-to-period shifts.</p> | Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a>       | Health system         | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | Finally, CMS seeks comment on whether it should move to an annual update cycle for the Overall Hospital Quality Star Rating, essentially tying the timing of the ratings cycle to measures that are refreshed annually (which include most of the underlying outcomes measures: PSI-90, hip/knee complications, EDAC measures, readmissions measures, and mortality measures). LVHN agrees if the latent variable modeling approach is revised refreshing the data annually instead of quarterly or biannually may improve the predictability of the star rating.   | Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network  | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a>                     | Health system          | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Period to Period Shifts – NO<br>One approach CMS is considering is a transition to reporting the Overall Hospital Quality Star Ratings once a year, rather than twice (as currently), so that changes in hospital ratings are more predictable based on changes in underlying measures. We do not support this change. We prefer the reporting to remain twice a year and appreciate having visibility into the loading coefficient shifts before the final reports are issued.   | Holly Wolfe, MBA, Director, Quality & Clinical Improvement, WellSpan Health  | <a href="mailto:hwolfe2@wellspan.org">hwolfe2@wellspan.org</a>                           | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Reduce the magnitude of Star Ratings shifts between Periods. Align Star Ratings refreshes with annual Hospital Compare reporting. Use rolling weighted combination of current and previous data.  | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital   | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | There are clearly conflicting viewpoints on the primary focus of hospital ratings. Many argue that the primary goal should be consistency and transparency, so that hospitals can predict their rankings. We, in contrast to many others, do not believe that the ability to predict rankings is an important goal. Hospitals are fully aware of the included measures, and there is no quality-related reason that advance knowledge of exact weights is necessary if we believe that the included measures are independently important indicators of quality. Consistency of ratings is a reasonable goal, but we do not believe this should be done by anchoring to past performance. Hospitals can clearly have changing performance, and this should be reflected in the rankings. | Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan | <a href="mailto:svijan@med.umich.edu">svijan@med.umich.edu</a>                           | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | The public input request notes that CMS considered ways to reduce the large shifts in the Overall Hospital Quality Star Ratings from year to year, including possibly moving to reporting ratings once per year, so that changes in hospital ratings are more predictable based on changes in underlying measures. Kaiser Permanente supports moving to a single, annual update of Overall Hospital Quality Star Ratings, both to temper the frequency of performance shifts and to promote alignment with other CMS quality ratings reporting systems such as the Medicare Advantage and Part D Star Ratings.  | Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals | <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a>                       | Hospital Association  | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <b>Cedars-Sinai agrees that the most current data should be used for each update of the Star Ratings. We also support an annual refresh schedule of the overall quality Star Rating</b> that assures all individual measures are updated prior to calculation of the quality Star Rating.   | Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center                | <a href="mailto:gail.grant@cshs.org">gail.grant@cshs.org</a>                         | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Although there is a benefit to have overlapping in timeframes in a data refresh so there isn't a sharp cutover, we more strongly support that hospitals and consumers are rated on the most recent and current data available. Currently, Star Ratings just recently published in February 2019 are based on performance data that go as far back as October 2015 (PSI-90) and through 2017. Consumers aren't always tuned into this even though it is posted on the Hospital Compare data tables. There needs to be more current data on Hospital Compare to consumers in order to support their decision making.<br>We support the proposal to refresh the Star Ratings to only once per year because of the imbalance in data published on the Hospital Compare website quarterly and annually leading to swings in the Star Ratings outcomes between the July and December refreshes. | Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital   | <a href="mailto:linnea.huinker@nrthmemorial.com">linnea.huinker@nrthmemorial.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | We also find it difficult to direct strategic focus on particular measurements, due to the change in loading coefficient values upon each reporting period. Regarding the annual refresh, we support this new process.  | Melissa Obuhanick, RN, BS, CPPS, CPHQ, Director of Quality and Risk Management; Grand River Hospital District           | <a href="mailto:mobuhanick@grhd.org">mobuhanick@grhd.org</a>                         | Hospital              | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure  | Text of Comment  | Name, Credentials, and Organization of Commenter  | Email Address*   | Type of Organization* | Response*                          |
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| 3/29/2019   | Period to Period Shifts | Once sharing the Star Rating information begins again, it will need to be regularly updated to keep it current for patients, while finding an effective way to account for rating shifts between reporting periods. Of the three options being considered, weighted average, incorporation of partial star ratings or an annual update cycle, we favor an annual update schedule. We are also interested in exploring the use of a partial rating which could better distinguish between high and low performers within a given level, whether for a single composite measure or for any sub-measures that get adopted.  | Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center  | <a href="mailto:Jennifer.carlson@osumc.edu">Jennifer.carlson@osumc.edu</a>       | Medical University    | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>4.4. Period-to-Period Star Rating Shifts</p> <p>CMS would like to gain public input on a potential option that would reduce period-to-period changes in the Overall Hospital Quality Star Rating by incorporating data from an older period.</p> <ol style="list-style-type: none"> <li>1. What are possible benefits and drawbacks to increasing stability by limiting change in this way?</li> <li>2. Should the Overall Hospital Quality Star Rating methodology be modified to incorporate data from previous periods through a time averaged approach?</li> <li>3. Are there other approaches to this CMS should consider?</li> </ol> <ul style="list-style-type: none"> <li>• We do not support incorporating the previous period's data into the Star Rating Methodology. We agree with the stakeholder groups that it is more important to use the most current data rather than including older data to determine star ratings.</li> <li>• We support refreshing Star Ratings only once annually when all performance data are refreshed. Given the current refresh periods for CMS, this would optimally occur in July of each year.</li> </ul> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a> | Medical University    | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | The underlying metrics which make up the Mortality, Readmission, and AHRQ Safety data are only updated for public reporting annually. Therefore, decreasing overall star updates to once yearly would be appropriate and decrease confusion around why the star rating may have changed for a facility when not all the data was updated. Additionally, using the most current data available would provide a more accurate reflection of the facility's performance rather than rating hospitals on their performance from several years prior.   | John D. Poe, Chair, Quality and Affordability, Mayo Clinic  | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a>           | Health System         | Please refer to the Summary Report |



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| 3/29/2019   | Period to Period Shifts | <p><u>2.</u> 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 efforts and for patients making important health care choices based on these ratings.</p> <p><u>a.</u> CMS should refresh star ratings on an annual basis to improve stability and minimize period-to-period rating shifts.</p> <p>Under the biannual schedule for 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.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System                       | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a>     | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | The Joint Commission supports changes to the rating methodology that reduce period-to-period variability while still maintaining the principles stated above. As such, The Joint Commission supports a single, annual refresh of Overall Hospital Quality Star Rating. An annual update schedule would ensure that hospital ratings align more closely with changes in the underlying measures incorporated in the rating methodology, while reducing variability.  | Patrick Ross, MPH<br>Federal Relations Specialist<br>The Joint Commission                          | <a href="mailto:PRoss@jointcommission.org">PRoss@jointcommission.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Regarding period to period shifts, the way CMS' methodology currently weights measures, a hospital may experience a significant shift in Star Ratings in one rating period. Swings like this point to a problem in the methodology in that the measures may not be weighted appropriately; or outdated data is used to determine the rating. The lag time in the data used also may not accurately reflect a hospital's current status. For example, data that is used to determine the rating for some metrics ranges from 7/2014 – 6/2017, and therefore does not demonstrate current practice. KHA encourages CMS to use more current data reflective of a hospital's performance.   | Karen Braman, Senior Vice President, Healthcare Strategy and Policy<br>Kansas Hospital Association | <a href="mailto:kbraman@khanet.org">kbraman@khanet.org</a>               | Hospital Association                            | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>Stability. Any fluctuations in star ratings across reporting periods should be driven by significant changes in underlying measure performance rather than by any inherent instability in the ratings methodology.</p> <p>While CMS canceled the July 2018 update to star ratings in part because there were significant changes to the ratings, these rating changes were not explained easily by a major change in underlying measure performance.</p> <p>A “line of sight” from star ratings to performance on underlying measures. Because star ratings are publicly reported, hospitals should be able to see, in a transparent and predictable fashion, how any positive or negative changes in underlying measure performance are reflected in their star ratings.</p> <p>Since the inception of the ratings, hospitals have expressed frustration that they have virtually no way to predict how their performance on the underlying measures will translate into a star rating. This means the ratings are of little value to improvement efforts. In fact, they actually could discourage improvement efforts when hospitals work hard to improve an aspect of care and then see their star ratings go down.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a>             | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | The star rating needs to change as data is submitted. Facilities have to submit quarterly and we suggest the Star Rating should match the data submitted with each data refresh   | Amy Arnett, MS, RN, CPHQ, CPPS Quality/Infection Prevention Manager Horizon Health  | <a href="mailto:aarnett@myhorizonhealth.org">aarnett@myhorizonhealth.org</a>   | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | CMS requests feedback on the benefits and drawbacks of refreshing the Overall Hospital Quality Star Rating only once a year. While Ascension continues to believe that the shift in star ratings from December 2017 to July 2018 was due to the LVM stability issues addressed above, we would support a once a year reporting of the star ratings due to the partial updates of data that occur over the year. However, we are concerned that modifying the current methodology to combine data across reporting periods seems too cumbersome, error prone, and could introduce other unintended consequences into the star ratings.   | Peter M. Leibold, Chief Advocacy Officer, Ascension   | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Period to Period Shifts | Report once per year with enough time prior to release for hospital review. Please consider quarterly or every 6-month updates before the final annual Hospital Compare is reported. These interim updates will allow hospitals and physicians to refine improvement initiatives. The interim updates can be driven by existing algorithms.   | Dale N. Schumacher, MD, MPH, President, Rockburn Institute              | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a>     | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p><u>a.</u> CMS should refresh star ratings on an annual basis to improve stability and minimize period-to-period rating shifts.</p> <p>Under the biannual schedule for 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.</p>           | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association                            | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p><u>b.</u> CMS should refresh star ratings on an annual basis to improve stability and minimize period-to-period rating shifts.</p> <p><u>c.</u> Under the biannual schedule for 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.</p> | Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System  | <a href="mailto:maria.iliescu@sinai.i.org">maria.iliescu@sinai.i.org</a>           | Health System                                   | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>While shifting to a less frequent release of Star Ratings might reduce the appearance of wild swings in the loading coefficients for the latent variable modeling process, the underlying problem is that latent variable modeling is not the best approach for the data.</p> <p>If the data is analyzed using defined measure weights, meaningful metrics are included, and appropriate peer groupings are established, VCU Health System supports refreshing Star Ratings on an annual basis. The release of ratings several time a year is not beneficial when some of the measures do not have new performance with each release.</p> | <p>Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckely, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality &amp; Safety First Programs; VCU Health System</p> | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>Once the Star Ratings are again ready for release upon resolving these issues, we stand with the AAMC in advocating for annual refreshes (potentially each July) to not only correspond with measures that only update annually on Hospital Compare, but also to allow sufficient opportunities for stakeholder and public feedback between cycles.</p>   | <p>Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center</p>   | <a href="mailto:Panzarellolm@upmc.edu">Panzarellolm@upmc.edu</a>     | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>6. Limit Star ratings release to a maximum of once per year. We feel multiple releases are confusing because some measurement periods are updated (patient experience and HAIs) while others stay the same (mortality and readmissions).</p> <p>7. Do not combine data from prior reporting periods. These result in even longer measurement periods. By incorporating older data, it may impede a hospital's ability to improve scores and reduce incentives for making actual improvements, and thus having minimal impact on actual patient care.</p>  | <p>Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health</p> <p>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health</p> | <p><a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a></p>       | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>Intertemporal smoothing would merely obscure the inherent instability of the LVM, but not fix it. In my paper, I present an example that demonstrates how an infinitesimal change in data (correlation) can result in a cataclysmic change in measure weights, a “knife-edge.” Another example shows how relatively weakly correlated measures can be extinguished from having weight. This behavior looks similar to the pattern of loadings seen in the Safety of Care group over time, not only in PSI-90 and Complications for Knees and Hips, but in earlier measures as well such as MRSA and C-Diff.</p> <p>As a result of these shifts, a hospital that improves along EVERY dimension may score lower. With the approach I propose, under reasonable conditions this cannot happen, i.e. hospitals that improve in every measure get higher scores. It is a mathematical property of the underlying optimization that an infinitesimal change in data can only result in an infinitesimal change in hospital score. Such “knife-edge” behavior cannot occur. (It would be sensitive, however, to large changes in denominators, as it should be.) Thus, my approach obliterates the need to intertemporally smooth so that ratings may represent the latest information available.</p> | Dan Adelman, Professor, University of Chicago Booth School of Business  | <p><a href="mailto:Dan.Adelman@chicagobooth.edu">Dan.Adelman@chicagobooth.edu</a></p> | Individual             | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>1. Our users had multiple comments on this point.</p> <ul style="list-style-type: none"> <li>• If this is done, it should be done with a calendar year reporting structure to align with other quality and incentive programs. Additionally, we would need to minimize the lag in any data. For instance, if an update is scheduled in January 2020, any and all data submissions and permission updates filed by 23:59:59 EST should be included in the update. See page 13 of the original request.</li> <li>• The goal of changing the update calendar from three separate calendars to a single calendar should be done to create a consistent data set. Multiple timeframes is hard on hospitals and consumers, and drives minimal improvement at the hospital level based on how traditional reporting to executives and the Board of Directors is usually completed.</li> <li>• This is common to weight previous and current performance in compensation models.</li> <li>• A popular idea from our users suggested a rolling quarter full update that lags no more than six (6) months. This would enable hospitals to start corrective actions more timely.</li> <li>• CMS should include previous data to act as a smoothing function. A common weighting is 25% old and 75% new, give or take a few percentage points in each category. We think CMS should be careful on how much historical data you bring into the score, though. The old data could act as an anchor to scores depending on the amount of weight applied to that category and the weight of each domain within historical data.</li> </ul> | Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System                             | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <ul style="list-style-type: none"> <li>• Not in favor of incorporating data from the prior period. Metrics like Mortality and Readmission already include multi-year data.</li> <li>• Support update annually, as many metrics are updated annually only (e.g. readmission, mortality, PSI, etc).</li> </ul>  | Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center | <a href="mailto:deede.wang@vumc.org">deede.wang@vumc.org</a>               | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | MGH endorses a change from a semiannual to an approach that would be no more frequent than an annual refresh for the Overall Hospital Quality Star Rating program on Hospital Compare. MGH agrees with stakeholder concerns that large shifts can be observed in a six-month period after only small changes in individual measure performance, making it difficult to explain these changes. Concerns held by MGH and other stakeholders can be diminished by moving to an annual release and allowing time for each measure to be refreshed prior to the star rating calculation.  | Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital | <a href="mailto:emort@partners.org">emort@partners.org</a>                         | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>The FAH supports shifting to annual reporting ratings from the current biannual schedule. This would provide increased stability to the ratings and would be consistent with the schedule of annual updates that are reported for most outcome measures. While one drawback to an annual assessment is that it limits the visibility of changes that may be improving or worsening scores when measure updates that do not fall within the yearly update take place. However, this lag would be no longer than 9 months in the worst case.</p> <p>The FAH does not support the use of weighted or time-average previous period data in calculating the Star Ratings. A hospital's past performance may not be the best predictor of current or future performance hence use of older information may well result in ratings that are not relevant to consumers who may rely on the star rating to choose a hospital for their care. Indeed, data lags for some measures already limit how current a reflection the Star Ratings provide.</p> <p>The FAH supports exploration of an alternative way of reducing period-to-period shifts through the use of three-star or partial-star categories rather than five-star. Three star categories would provide patients with information on outliers which is helpful in guiding consumer choice while likely introducing improved consistency from period-to-period. Partial star ratings might provide more clarity if implemented correctly. The FAH supports empiric evaluation and consumer testing of such an approach.</p> | Chip Kahn, President, CEO, Federation of American Hospitals   | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a>                           | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | Like many hospitals across the country, SSM Health wants to have a better understanding how our performance in the measure will impact our future star ratings. Each year we strive to improve the quality of care we provide to our patient; however, the current star rating program doesn't provide our organization clarity into whether improvement efforts will improve our star rating  | Michael D. Richards, System Vice President, Government Affairs and Public Policy; SSM Health                              | <a href="mailto:Michael.richards@ssmhealth.com">Michael.richards@ssmhealth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | We believe it is of paramount importance that any quality ratings system reflects current, on-the-ground quality to the greatest extent possible. Consistency for its own sake is not a legitimate ends if underlying quality is indeed shifting. The quality measures already reflect information that is sometimes many years old; weighting between “current” and prior ratings would exacerbate this problem. Indeed, implementing this proposal would be a disservice to consumers.                       | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                             | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | I’m on the side of this argument that the star rating should be focused on the most current data available so the idea of bringing in more ‘old’ data is unfavorable. I would instead suggest reducing the current 3 year period for the measures in the readmission and mortality domains to one year; a three year period doesn’t make sense from a quality perspective and isn’t consistent with the measure periods in the other domains.  | Laura Morris, MS, CPHQ, Senior Business Analyst for Quality  | <a href="mailto:lmorris@glensfalls.hosp.org">lmorris@glensfalls.hosp.org</a>       | Individual             | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | The current data lag in Overall Hospital Quality Star Rating is long, and heavily-weighted domains of Mortality, Readmissions and Safety of Care currently report prolonged performance periods. As calculation and reporting methods allow inclusion of more timely data, stabilization with a 75%-25% method will smooth period-to-period scores in a useful way. In current state, however, any attempts to incorporate older/historic data will further obscure improvements organizations make over time. | Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care  | <a href="mailto:hahncoverk@health.missouri.edu">hahncoverk@health.missouri.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/29/19     | Period to Period Shifts | <ul style="list-style-type: none"> <li>• Incorporating older data into current scores penalizes those hospitals that are working to improve. Many of these data sets are going back two or three years as is and it takes years to improve scores. Much of the data is already old and not reflective of the care provided at the time the data is published and available to the public.</li> <li>• The major reason that many of these hospitals changed star ratings by so much was due to the change in loading values for PSI-90 and COMP-HIP-KNEE. These two metrics alternated refreshes as the highest weight in the safety of care measure group. When the highest weight, each metric had a completely dominant effect on the total score of that group.</li> <li>• I also disagree with only refreshing the overall rating once a year. Again, this penalizes the hospitals that are working to improve. Consumers and the Public deserve to see the most recent information and data available.</li> </ul> | Jean Cherry, FACHE, Executive Vice President, Med Center Health                | <a href="mailto:jean.cherry@mchealth.net">jean.cherry@mchealth.net</a>         | Healthcare System      | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | Regarding performance periods and updates of publicly displayed data. The most recent variance in methodology, including weighting and look back periods, has resulted in a significant shift in Star ratings that was unpredictable to hospitals. In addition, the expanded look period further dilutes any current value to the consumer, as the "star" being reviewed is reflective of performance data no more recent than one year and as far back as three years. Not only does this methodology not give the consumer information about a hospital's current performance, it also takes two and sometimes three years for past performance to be removed from the current rating. Therefore, a hospital could be a very high or very low star rating for two years with no correlation to current performance. Olathe Medical Center encourages CMS to use more recent data reflective of a hospital's current performance.   | Cathy Wiens, MHA, Vice President/Quality and Compliance; Olathe Medical Center | <a href="mailto:cathy.wiens@olathehealth.org">cathy.wiens@olathehealth.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>Low patient volume also decreases star rating predictability each time CMS updates the ratings. With the potential for large swings in quality scores based on individual patient outcomes, it is difficult, if not impossible, for CAHs to accurately predict their score from update to update, let alone build momentum for high quality scores under CMS's current methodology. Any updates CMS makes to the Star Rating Program should include methods to smooth out these issues for small hospitals and provide predictability year-over-year.</p> <p><b>Recommendation</b></p> <p>On a final note, Carthage recommends that CMS move to annual updates for star ratings, rather than trying to update rankings twice per year. Annual rankings would allow for a longer lead time to address any issues identified by hospitals, and would also permit CMS to more easily implement recommended stakeholder engagement mechanisms to improve the accuracy and reliability of the Star Rating Program.</p>   | Rob Bloom, CFO;<br>Carthage Area Hospital  | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a>                           | Hospital                                   | Please refer to the Summary Report |
| 3/29/2019   | Period to Period Shifts | <p>Vizient encourages CMS to rely on consistent measure and measure group weighting that is updated on an annual basis.</p> <p>Vizient continues to believe the root cause of the period-to-period variation is driven by measure loading coefficients generated from using latent variable modeling – and exacerbated by the current lack of hospital groupings. Trying to smooth out that variation by simply blending the old rating and the new rating is not an effective solution. Many of the heavily weighted CMS measures, such as the measures in the readmissions, safety and mortality groups are considerably dated, some going as far back as 2014, for the collected measures reported in the February 2019 CMS Hospital Star Ratings. Incorporating data from a previous time period would further limit the utility of the Star Ratings. Vizient recommends the use of more timely data, more stable measure weighting approach and creating hospital groupings to minimize period-to-period Star Rating shifts – which would offer a more contemporary look at how a hospital is currently performing.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |



| Date Posted | Measure Set or Measure  | Text of Comment  | Name, Credentials, and Organization of Commenter                                    | Email Address*   | Type of Organization *                          | Response*                          |
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| 3/29/2019   | Period to Period Shifts | The foundation of the methodology is a complex statistical technique that lacks transparency and creates uncertainty by disproportionately and inconsistently weighting measures within groups. CMS is utilizing a latent variable model (LVM) to calculate a numerical “loading factor” for each star rating measure. The higher a measure’s loading factor, the more it drives performance within a particular measure group. The inability to predict the weight of a measure creates instability in the program. Stability is critical as these measures are leveraged by providers who desire to use the star rating to drive quality improvement and for patients who make important healthcare choices based on these ratings. CMS should create a transparent model for star ratings that is reliable and can be effectively replicated. Subtle changes in the underlying data observed in a six-month period can change a rating, particularly for hospitals with borderline scores, under the current update schedule. These changes are a major contributor to the instability of the rating. In addition, the performance period of individual measures varies, with some measures based on one year of data and others three years of data. Premier supports the transition to an annual refresh of the star rating and recommends that the agency seek to align measure timeframes with other programs in order to promote transparency and reduce burden to providers. We also believe that CMS should assess the volatility of a measure period to period. Any measure with volatility year to year should be removed from the star rating due to lack of reliability. | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/2019   | Period to Period Shifts | <p>Although the benefits of using weighted averages can lead to less variation in performance and less variation to the star ratings, there is a drawback when hospitals achieve significant performance improvement in more current periods. The weighted average reduces the impact of that performance improvement on the star rating. Another drawback is that many of the measures are already based on old performance (three years back). Incorporating previous performance periods would expand the lookback period for hospitals' performance even more and would not be an accurate reflection of their current performance. This would make it more difficult for hospitals to make any substantive strides and achieve a higher star rating.</p> <p>AHPA believes that previous periods should not be considered in the calculation of star ratings. Star ratings should be updated annually after all measures refresh. This approach would provide more accurate and meaningful information to consumers. AHPA recommends including weighted averages for measures that contain no overlapping data and current data for measures with overlapping data. Ideally, all measures should be calculated based on current year data, rather than three-year lookback periods. Currently, measures are calculated over different periods, sometimes even within a group. To mitigate any adverse impact from this difference, consistency could be achieved by using the weighted average over the same period for measures with no overlapping data. CMS could also consider using a two-year lookback period for all measures. This approach provides more current data and can demonstrate a hospital's improvement sooner than the current three-year period used among several measures.</p> <p>AHPA recommends that CMS refresh the ratings annually. Biannual ratings may cause confusion among consumers, particularly if they choose a facility based on its star rating to then realize that the rating changed within a couple of months.</p> | Carlyle Walton, FACHE, President; Adventist Health Policy Association | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System     | Please refer to the Summary Report |
| 3/29/19     | Period to Period Shifts | An annual public release seems reasonable but having a non-pubic update of the results for the hospitals quarterly, or at least mid-year, would be preferable.  | Laura Morris, MS, CPHQ, Senior Business Analyst for Quality           | <a href="mailto:lmorris@glensfalls.org">lmorris@glensfalls.org</a>                   | Individual            | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure  | Text of Comment   | Name, Credentials, and Organization of Commenter  | Email Address*                                       | Type of Organization*   | Response*                             |
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| 3/29/2019   | Period to Period Shifts | <p>Volatility in the star ratings from period-to-period has led to concerns about the validity of the underlying methodology. In an effort to improve the consistency of ratings between periods, CMS proposes to supplement the current period reported data with prior period data and compute a weighted average of the summary scores for each period. In addition, CMS proposes to release star ratings updates annually rather than twice per year.</p> <p>GNYHA opposes incorporating prior period data into the model because it would not improve the model fit and would increase the lag between the performance period and the evaluation period. Instead, we urge CMS to continue exploring statistical model improvements to address the period-to-period shifts in the star ratings. Also, while we would support reducing the frequency of star ratings updates to annually (once the methods are improved and determined to be statistically valid), we do not view this as a solution for addressing the model's current flaws.</p> | Elisabeth R. Wynn,<br>Executive Vice President,<br>Health Economics &<br>Finance, Greater New<br>York Hospital<br>Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a> | Hospital<br>Association | Please refer to the<br>Summary Report |

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| 2/28/2019   | Peer Grouping          | <p>1.Socioeconomic status is not adjusted for in the Star rating, but is adjusted for in the HRRP. This adversely affects urban hospitals.</p> <p>The association of low socioeconomic status and readmission outcomes has been well established, and many have advocated for adjustment of readmission rates for socioeconomic status(ref 3–6). The 21st Century Cures Act legislated the requirement of inclusion of socioeconomic status (SES) into the calculation of financial penalties within HRRP. Bernheim et al(ref 7) showed a statistically significant relationship of socioeconomic factors, such as median income, to readmission rates for AMI, HF, and PN. SES factors were of higher impact than over 1/3rd of medical comorbidities included in the readmission models.</p> <p>CMS’ Overall Rating program exclusion of SES from the Readmission domain creates inconsistency from CMS’ HRRP. Our own research found that the Summary score of the Dec 2017 Overall Rating had statistically significant correlation with the proportion of dual eligible patients, data supplied by the HRRP program. The following are a few examples of Illinois hospitals that would change star ratings based on socioeconomic status correction based on proportion of dual eligible patients.</p> <p><a href="#">[Table 12a]</a> <a href="#">[Table 12b]</a> Rush changes to Overall Ratings from SES Inclusion]</p> <p>* SES Correction would change RUMC’s Feb 2019 preview 4 star to a 5 star</p> <p>Data obtained from FY2019 IPPS Final Rule Data Tables and Overall Rating SAS code from qualitynet.org. Data obtained from FY2019 IPPS Final Rule Data Tables and Overall Rating SAS code from qualitynet.org</p> <ul style="list-style-type: none"> <li>• Socioeconomic status was legislated to be included when calculating readmission penalties because SES matters. SES impacts outcomes and should be addressed in the Overall Rating model.</li> </ul> <p>References</p> <p>3. Boozary AS, Manchin J, Wicker RF. The Medicare Hospital Readmissions Reduction Program: Time for Reform. JAMA. 2015 Jul 28;314(4):347–8.</p> <p>4. Carey K, Lin M-Y. Hospital Readmissions Reduction Program: Safety-Net Hospitals Show Improvement, Modifications To Penalty Formula Still Needed. Health Affairs. 2016 Oct;35(10):1918–23.</p> | <p>Thomas Webb, MBA, Manager, Quality Improvement;</p> <p>Bala Hota, MD, Vice President, Chief Analytics Officer, Associate CMO, Associate CIO, Professor in Section of Infectious Diseases/Department of Medicine;</p> <p>Omar Lateef Stuart Levin, MD Presidential Professor of Rush University, Professor, Critical Care Medicine, Senior Vice President and Chief Medical Officer;</p> <p>Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University    | Please refer to the Summary Report |

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|-------------|------------------------|--|--|---|------------------------|------------------------------------|
| 2/28/2019   | Peer Grouping          | <p>5. Figueroa JF, Joynt KE, Zhou X, Orav EJ, Jha AK. Safety-net Hospitals Face More Barriers Yet Use Fewer Strategies to Reduce Readmissions. Medical Care. 2017 Mar;55(3):229.</p> <p>6. Refining the hospital readmissions reduction program [Internet]. [cited 2019 Jan 16]. Available from: <a href="http://www.medpac.gov/docs/default-source/reports/jun13_ch04.pdf">http://www.medpac.gov/docs/default-source/reports/jun13_ch04.pdf</a></p> <p>7. Bernheim SM, Parzynski CS, Horwitz L, Lin Z, Araas MJ, Ross JS, et al. Accounting For Patients' Socioeconomic Status Does Not Change Hospital Readmission Rates. Health Aff (Millwood). 2016 Aug 1;35(8):1461–70.</p> | <p>Thomas Webb, MBA, Manager, Quality Improvement;</p> <p>Bala Hota, MD, Vice President, Chief Analytics Officer, Associate CMO, Associate CIO, Professor in Section of Infectious Diseases/Department of Medicine;</p> <p>Omar Lateef Stuart Levin, MD Presidential Professor of Rush University, Professor, Critical Care Medicine, Senior Vice President and Chief Medical Officer;</p> <p>Rush University Medical Center</p> | <p><a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a></p>                         | Medical University     | Please refer to the Summary Report |
| 3/6/2019    | Peer Grouping          | <p>3. Factor in challenges of safety net hospitals in addressing social determinants</p> <p>4. Rate hospitals in comparison to like facilities (similar to the Watson categories)</p>  | <p>Patricia D. Boyette, MSHS, BSN, NE-BC Director, Operational Performance Improvement Corporate Quality, Orlando Health</p>   | <p><a href="mailto:Patricia.Boyette@orlandohealth.com">Patricia.Boyette@orlandohealth.com</a></p> | Health System          | Please refer to the Summary Report |

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| 3/11/2019   | Peer Grouping          | Consideration should be given to creating a risk adjusted approach to normalizing the comparative data. One example might be to factor in the Case Mix Index which is an indicator of case complexities for the hospital. Trauma centers, cancer centers, and burn centers will all have more readmissions, more infections, more mortalities, etc. Current Star Ratings do not take these variables into account.  | Monica Hamilton, MHA, BSN, RN, CPQH, Natividad   | <a href="mailto:hamiltonm@natividad.com">hamiltonm@natividad.com</a>                   | Hospital              | Please refer to the Summary Report |
| 3/6/2019    | Peer Grouping          | Definitely add peer-grouping. I do recommend having two-star ratings: one overall and one for peer-grouping. Recommend displaying: academic/teaching, rural, community for profit, community non-for profit, nonacademic/teaching, critical access. Beds: < 50, 51 – 99, 100 – 299, 300 – 499, > 500.   | Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare             | <a href="mailto:RHyke@stanfordhealthcare.org">RHyke@stanfordhealthcare.org</a>         | Individual            | Please refer to the Summary Report |
| 3/12/2019   | Peer Grouping          | Please address the known disparity between Major teaching hospitals (which typically treat complex conditions for patients with various socio-economic factors) and specialty hospitals that often work with insured patients on elective procedures. It would be appropriate to stratify hospitals into a series of peer groups based on influencing metrics (precedence set by FY2019 HRRP). Note that 52.5% of the 40 four- and five-star major teaching hospitals performed below average on readmissions which points to an inequality in patient frailty. | Adam Felton, MS, Manager: Clinical Information Analysis, Norton Healthcare               | <a href="mailto:Adam.Felton@nortonhealthcare.org">Adam.Felton@nortonhealthcare.org</a> | Individual            | Please refer to the Summary Report |
| 3/12/2019   | Peer Grouping          | Please consider stratification of like type hospitals similar to the RRP quintiles. Please do not use the same methodology for peer group selection as RRP (dual eligibility) as it does a very poor job of grouping.   | Adam Felton, MS, Manager: Clinical Information Analysis, Norton Healthcare               | <a href="mailto:Adam.Felton@nortonhealthcare.org">Adam.Felton@nortonhealthcare.org</a> | Individual            | Please refer to the Summary Report |
| 3/11/2019   | Peer Grouping          | One star rating would be preferable to two to promote transparency of results to healthcare consumers who use Hospital Compare data. Peer grouping would be beneficial to hospitals for results but would likely be confusing to consumers. In addition, peer grouping is sometimes not just determined by size or type of facility but by the services provided by the hospital, so CMS should account for those differences if it decides to include Peer Grouping in star rating.  | Rhonda Unruh, MHA, RN, CIC, Vice President of Quality, Guadalupe Regional Medical Center | <a href="mailto:runruh@grmedcenter.com">runruh@grmedcenter.com</a>                     | Individual            | Please refer to the Summary Report |

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| 3/12/2019   | Peer Grouping          | I would like to see the methodology not positively impact facilities that have limited populations or services. Currently, facility that offer broader services are penalized for poor performance compared to facilities that are rewarded for better performance with a very small population size or exemption. A hospital should have negative consequences for not providing a service or specialty to a community. The rating should include flexibility for complexity. The rating is misleading the consumers who think a higher rated facility provides better care but in truth, a higher rated facility many have a slim specialty services and would potential transfer complex patients to be “cared for”. | Stephanie Parson   | <a href="mailto:Stephanie.Parson@sparkshealth.com">Stephanie.Parson@sparkshealth.com</a> | Individual            | Please refer to the Summary Report |
| 3/12/2019   | Peer Grouping          | There needs to be a solution for small rural hospitals. Without the numbers to generate true scoring, it is unfair to give ratings in this way. Please revise this.   | Heather Reynolds, MSN, RN, Director of Quality, The University of Vermont Health Network, Elizabethtown Community Hospital | <a href="mailto:hreynolds@ech.org">hreynolds@ech.org</a>                                 | Individual            | Please refer to the Summary Report |
| 3/13/2019   | Peer Grouping          | Asante would also request hospitals not be placed in categories in relation to dual eligibility for the purpose of comparative analytics. This use of dual eligibility as an indicator for socioeconomic factors is flawed, as there are other factors that influence dual eligibility status unrelated to socioeconomics. Further, consumers have little awareness or investment into which category their local hospitals are placed.   | Jamie Grebosky, MD, Asante Chief Medical and Quality Officer, Vice President, Medical Affairs AACH                         | <a href="mailto:JAMES.GreboskyMD@asante.org">JAMES.GreboskyMD@asante.org</a>             | Health System         | Please refer to the Summary Report |
| 3/14/2019   | Peer Grouping          | They asked about social risk factors and whether CMS would do this at the Star Ratings level. They did not say in favor one way or the other.   | Missouri Hospital Association  | Forwarded by CMS leadership  | Hospital Association  | Please refer to the Summary Report |

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| 3/14/2019   | Peer Grouping          | <p>Hospital Compare Star Ratings</p> <p><a href="#">[Figure 6]</a> At one time there were EACH program hospitals in rural areas. It is my understanding they no longer exist or maybe 1 or 2??</p> <p>What I would want to know as a consumer is the overall rating of the hospital, but also information about specific procedures.</p> <p>EX. Total Knee replacement—infection rate, number done per year, other complication rate, revisions, LOS</p> <p>The procedures could be picked: 10 most common OR procedures, OR most costly, OR most utilization variation by Dartmouth Atlas (targeting might help to decrease the overuse).</p> <p>There may be further subdivision, but this is a starting point.</p> <p>For the rural hospital CAHs, they would be scored on what they are mandated to perform. However, some CAHs are doing more, because of telehealth, environmental issues that prevents transfer, etc. So CAHs may need to be subdivided.</p>  | Nancy L. Fisher, MD, MPH, Centers for Medicare & Medicaid, Chief Medical Officer, Region 8,9,10          | <a href="mailto:NANCY.FISHER@cms.hhs.gov">NANCY.FISHER@cms.hhs.gov</a><br>Forwarded by CMS leadership | Individual            | Please refer to the Summary Report |
| 3/14/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>Would it be valuable to calculate Overall Hospital Quality Star Ratings among peer groups? How should the information be displayed? If CMS decides to move forward with this feature, which stakeholders do you believe would use the information and how would they use it?</li> </ul> <p>In general, this could be valuable, but we agree with the previous TEP and stakeholder groups that it could also be confusing. A hospital's two or three different star ratings depending on alternative peer groupings could be difficult for consumers to interpret and for the hospital to explain.</p> <p>That said, it would be useful to have perhaps at least one peer-grouping option in use (see notes on the options below), with the presentation on the CMS web site clearly organized so that a user can go to one page or tab and see one Star rating, and then go to a different page or tab and see the other. Consumer focus groups could help inform CMS on exactly how to do this best.</p> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a>  | Health System         | Please refer to the Summary Report |



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| 3/14/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>• Among the feasible variables that could be used for peer grouping (specialty, number of measures reported, teaching status, number of beds, critical access hospital, proportion of dual eligible patients), which would be most useful? Descriptions for each mentioned variable are included below.</li> <li>• Proportion of dual-eligible describes the proportion of patients eligible for both Medicare and Medicaid. Dual-eligible could be used to peer group hospitals with similar proportions of duo/- eligible patients by quintile, for example.<br/>This is a plausible option, specifically because of its use already in the Hospital Readmissions Reduction Program {HRRP}. Having a consistent peer-grouping system across multiple measurement and P4P programs is attractive as a concept.</li> <li>• Teaching hospitals are those that have one or more accredited residency programs or have an intern or resident to bed ratio of 0.25 or higher. Teaching and non-teaching hospitals may differ in mission, financial considerations, and services. Teaching status could be used to peer group teaching and non-teaching hospitals.<br/>This is also an intuitively reasonable option, since other rating systems like US News routinely separate major teaching hospitals from smaller community hospitals, even if the community hospitals have some teaching activity. The challenge here is to find a way to create meaningful divisions, since teaching activity as measured by something like resident/bed ratio follows a continuous distribution without obvious break points. There are "major" teaching hospitals, "minor" teaching hospitals, and non-teaching hospitals, but all possible cutpoints to define categories are arbitrary. There would also have to be some kind of theory or conceptual rationale for use of teaching status as opposed to "safety- net" status as a grouping concept.</li> </ul> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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| 3/14/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>Number of beds at a hospital is a proxy for hospital size. Smaller hospitals may have fewer services and resources while larger hospitals tend to be in urban areas and may serve disadvantaged populations. This would seem like one of the least useful options, as the qualifiers here like "may have" or "tend to be" are important. In the absence of any clear evidence linking bed size to performance in the Star Rating system or on specific component measures (and in a consistent direction among measures), this would not be a good grouping variable.</li> <li>Hospitals that report more measures may not be directly comparable to hospitals that report fewer measures. Number of measures reported could be used to group hospitals by quartile, for example. This would be our preference among the listed options. The relationship between number of measures reported and Star Ratings is clear and compelling and is illustrated in Figures 7 and 8. Others have also noted and commented on this relationship. Hospitals that report few measures are qualitatively different from hospitals that report all measures - particularly in the sense of being niche, specialty hospitals rather than full-service hospitals with Emergency Departments (EDs) and significant charity care missions. There is a challenge here of deciding what the cutpoints should be for grouping on the basis of number of measures reported, but some basic statistical analyses should be able to identify the optimum cutpoints for purposes of creating groups that are internally similar but different from other groups. A quick "eyeball" test of Figure 8 might suggest three groups with cutpoints at 25 and 37 measures. A careful empirical analysis can surely do better than this.</li> <li>Certain rural hospitals can qualify for critical access designation for CMS purposes to indicate lack of proximity to other hospitals for prospective patients. Hospitals could be grouped as either critical access or non-critical access.</li> </ul> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a> | Health System         | Please refer to the Summary Report |

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|-------------|------------------------|--|---|--|------------------------|------------------------------------|
| 3/14/2019   | Peer Grouping          | <p>This method makes intuitive sense and can be done objectively on the basis of an existing Critical Access Hospital (CAH) designation. Doing this, though, seems also to defeat the purpose of the Star Rating system. If a consumer lives in a rural area with only one local hospital, what value is there in a rating system that compares that hospital with others 100 or more miles away? Hospital administrators might find value in that kind of peer comparison, but then their focus would and could be on individual measures rather than a global Star rating, so they can do this already with information in Hospital Compare.</p> <ul style="list-style-type: none"> <li>Specialty hospitals are those that primarily or exclusively engage in the care and treatment of patients with cardiac conditions, orthopedic conditions, conditions requiring surgical procedures, or other specialized services. Hospitals could be grouped and compared to specialty or non-specialty. <ul style="list-style-type: none"> <li>This would be a conceptually useful grouping mechanism and would function more or less like a grouping based on number of measures reported. Some exploratory analysis can determine which hospitals and how many hospitals would end up in different groupings if the groupings were based on specialty designation vs. number of measures reported. Doing this method would depend on some clear, objective designation of specialty hospitals.</li> </ul> </li> </ul> | Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System                                    | <a href="mailto:bchu1@hfhs.org">bchu1@hfhs.org</a>                         | Health System          | Please refer to the Summary Report |
| 3/15/19     | Peer Grouping          | <p>-If you were going to develop peer groupings they should align with other Publicly reported Hospital data such as Watson Health.</p> <ul style="list-style-type: none"> <li>-However, prefer current analysis using all hospitals that participate in HC instead of going to peer grouping</li> </ul>   | Kathy J. Nunemacher MSN, RN, CPN, CPHQ St. Luke's University Health Network Network Director Clinical Quality Data Governance and Reporting | <a href="mailto:Kathy.Nunemacher@sluhn.org">Kathy.Nunemacher@sluhn.org</a> | Individual             | Please refer to the Summary Report |

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| 3/18/2019   | Peer Grouping          | On the question of whether to offer more than one rating per hospital (one across all hospitals and a second one against a peer group of hospitals with similar demographic and health-related profiles), we recommend the multiple rating approach since it will provide greater insight to both patients and providers in ascertaining the value and validity of the star ratings being provided. The only challenge will be to make sure the visual representation on Hospital Compare makes clear the distinction between the two measures so a user can easily and quickly distinguish how they differ in composition and what they represent. Something like parallel columns with clear explanations at the top of each, for example, would be a terrific addition to the service. | Vytas Kisielius, Chief Executive Officer, ReferWell  | <a href="mailto:vytas@referwell.com">vytas@referwell.com</a>                     | Healthcare Performance Improvement Co. | Please refer to the Summary Report |
| 3/18/2019   | Peer Grouping          | Aligning adjustment for socio-economic status in the stars program to that of the Hospital Readmissions Reduction Program would be a logical and consistent method for measuring quality.   | Autumnjoy Leonard, Clinical Quality Compliance Auditor, Summit Healthcare Regional Medical Center                            | <a href="mailto:aleonard@summithealthcare.net">aleonard@summithealthcare.net</a> | Hospital                               | Please refer to the Summary Report |
| 3/19/2019   | Peer Grouping          | Perhaps the most important issue not addressed in the current STAR rankings are the social determinants of health. Numerous studies support that these are critical contributors to mortality, readmissions, etc. yet these are continually ignored in the STAR rankings despite numerous well-publicized calls for this to be considered.  | Seger S. Morris, D.O., MBA, Hospitalist & Associate Clinical Professor of Internal Medicine, Magnolia Regional Health Center | <a href="mailto:SMorris@mrhc.org">SMorris@mrhc.org</a>                           | Individual                             | Please refer to the Summary Report |
| 3/19/2019   | Peer Grouping          | <b>Peer Grouping:</b> Hospital size can sometimes bias results, primarily for readmission measures where CMS risk-adjustment favors smaller hospitals (statistical shrinkage in regression analysis). Lee Health campuses typically fall into “large” cohorts based on bed size. Additionally, as Florida is a state without Medicaid expansion, groupings such as Dual-Eligible population (as used in HRRP) can create discrepancy when compared to those states that did expand Medicaid, therefore we would recommend peer grouping with consideration to bed size.   | Raymond Pugh, Clinical Optimization Specialist II, Lee Health  | <a href="mailto:raymond.pugh@leehealth.org">raymond.pugh@leehealth.org</a>       | Health System                          | Please refer to the Summary Report |

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| 3/21/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>Would it be valuable to calculate Overall Hospital Quality Star Ratings among peer groups? How should the information be displayed? If CMS decides to move forward with this feature, which stakeholders do you believe would use the information and how would they use it?</li> </ul> <p>It might be valuable to hospitals to rate within peer groups, but it would not be helpful to consumers. Consumers may not recognize the difference in types of hospitals and they will likely be comparing based on geographic location. It would be difficult to explain why hospitals are not all compared to one another. The methodology already accounts for some hospital size differences using denominator weights, minimum number of patients for each measure, and minimum number of measures to calculate a rating. Hospitals would use this information as another benchmarking tool if scored against peers instead of everyone. If peer grouping was done it should be done as a supplement to the overall rating comparing all hospitals. Filtering could be useful if done by geography and could be driven by the consumer.</p> <ul style="list-style-type: none"> <li>Among the feasible variables that could be used for peer grouping which would be most useful?</li> </ul> <p>It would make sense to align the peer grouping methodology with that already used in the Hospital Readmissions Reduction Program. A strong rationale would need to be provided for employing a different methodology in another hospital program that also uses readmission measures.</p> | Jennifer Lamprecht, MS, RN, CNL, CPHQ<br>Director Quality Strategy<br>Sanford Health                  | <a href="mailto:Jennifer.Lamprecht@SanfordHealth.org">Jennifer.Lamprecht@SanfordHealth.org</a> | Health System         | Please refer to the Summary Report |
| 3/21/2019   | Peer Grouping          | OHSU supports the proposal to create ‘like-me’ hospitals, such as an Academic Medical Center cohort.  | Elana Zuber, MBA<br>Quality Management System Program Manager<br>Oregon Health and Science University | <a href="mailto:matere@ohsu.edu">matere@ohsu.edu</a>   | Medical University    | Please refer to the Summary Report |

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| 3/21/2019   | Peer Grouping          | Hamilton General Hospital (Hamilton, TX) a 5-star CAH;<br>We are neutral on peer grouping. We have a different take on what other rural or CAHs may think about peer grouping but we are a 5-star CAH and do not support any peer grouping effort that will impact our performance. It is possible to provide quality care and be a 5-star CAH. We believe that patients in CAHs should have the same quality of care that a urban academic hospital provides and that is the purpose of the Star Ratings.  | Hamilton General Hospital  | Forwarded by CMS leadership  | Hospital               | Please refer to the Summary Report |
| 3/21/2019   | Peer Grouping          | I also think two sets of scores would be helpful: <ul style="list-style-type: none"> <li>An overall score (Star rating) in comparison to all other hospitals</li> </ul> An overall score (Star rating) in comparison to similar hospitals (by size, geography and/or teaching status)   | David Raymond, MPH, President, Clinical Financial Management Associates, LLC                                       | <a href="mailto:draymond@clinicalfinancial.com">draymond@clinicalfinancial.com</a> | Individual             | Please refer to the Summary Report |
| 3/22/2019   | Peer Grouping          | WHA strongly discourages peer grouping and the creation of multiple star ratings for a hospital. This multiplicity will complicate transparency and add unnecessary burden to the program. Hospital Compare already lists an additional star rating for survey of patient experience data. Our members and the public already contend with multiple star ratings, rankings, and best lists published by a variety of sources”.  | Melissa Bergerson, RN, BSN, MHA, Chief Nursing Officer, Black River Memorial Hospital                              | <a href="mailto:BergersonM@brmh.net">BergersonM@brmh.net</a>                       | Hospital               | Please refer to the Summary Report |
| 3/22/2019   | Peer Grouping          | Specialty hospitals comprise 30%-40% of the five-star hospitals in the 2017 data run. The scope of practice for specialty hospitals is far more limited than the work of a general acute care hospital. There appears to be an advantage to hospitals with less volume and less data for the ratings. In the current data, it is almost impossible to be a one-star hospital if only three domains of data are sent (one hospital out of 283) and extremely unlikely if four domains are sent (four hospitals out of 270). Yet, 10% of hospitals submitting all seven domains of data are rated as one-star. This suggests a methodological bias in favor of less data. The pattern may reflect the current threshold for inclusion, which requires only three domains and nine total metrics (only 20% of total metrics). A domain score should require at least 50% of the measures in the domain, if not more. | Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University | <a href="mailto:bruce.meyer@jefferson.edu">bruce.meyer@jefferson.edu</a>           | Health System          | Please refer to the Summary Report |

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| 3/22/2019   | Peer Grouping          | <p>We suggest that CMS significantly raise the threshold for inclusion. We also suggest that CMS compare critical access hospitals to like hospitals, smaller hospitals by bed size with like hospitals and larger hospitals to like hospitals. We favor including teaching status as well. We suggest that CMS rate each hospital once with stars and then describe the category: large teaching, small teaching, small community, large community, critical access or specialty. Ideally, orthopedic specialty hospitals would only be compared with like hospitals, as that is a unique niche.</p> <p>Another concern is the lack of socioeconomic adjustment in the STARS rating methodology. Thus, the methodology favors suburban hospitals which outperform urban or rural counterparts serving more vulnerable communities. We strongly recommend that any hospital-to-hospital comparison include robust adjustment for socioeconomic factors. Social determinants of health are a risk factor for poorer outcomes, similar to comorbid illness. ICD-10 codes capture some of these including homelessness . We suggest CMS create a socio- economic adjustment and apply it in these scorings.</p> | Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University | <a href="mailto:bruce.meyer@jefferson.edu">bruce.meyer@jefferson.edu</a>           | Health System         | Please refer to the Summary Report |
| 3/25/2019   | Peer Grouping          | <p>Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.</p>  | Alison L. Hong, MD, Chief Quality Officer, St Peter's Health Partners  | <a href="mailto:Alison.Hong@trinity-health.org">Alison.Hong@trinity-health.org</a> | Health System         | Please refer to the Summary Report |

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| 3/25/2019   | Peer Grouping          | <p>Recommendation #2 – CMS should account for differences in hospital type when determining Star Ratings. Benefis shares the concern that has been raised via numerous articles to-date regarding the Star Rating system’s current failure to account for differences among hospital types. Reports that 61% of specialty hospitals nationally receive five-star ratings while only 9% of major teaching hospitals receive such ratings clearly indicate a problem with the current system. Our market perfectly illustrates the type of competitive environment in which specialty hospitals gain advantage over other hospitals as a result of the Star Rating system being skewed in specialty hospitals’ favor. With 332 licensed inpatient hospital beds, nearly 300 employed providers, and additional offerings ranging from longterm care to hospice and home health, Benefis provides a variety of services to patients across a vast service area. Providing safe, efficient, and effective care throughout such a robust continuum comes with many challenges, particularly given Benefis’ 76% governmental payor mix. In contrast, the Great Falls Clinic Hospital is a 19-bed for-profit physician-owned hospital located just a few blocks away from Benefis’ main campus. The Great Falls Clinic Hospital provides limited non-trauma emergency services and does not have any critical care, intensive care, or specialized pediatric inpatient services. Patients presenting to the Great Falls Clinic Hospital with chest pain, stroke symptoms, trauma, and other critical issues are subsequently transferred three blocks to Benefis via ambulance. While the Great Falls Clinic Hospital reports enough CMS quality data to receive an Overall Hospital Quality Star Rating, the specialty hospital’s patient demographic and complexity/acuity are vastly different from that at Benefis. Yet, currently such dynamics are given little to no consideration in calculating Star Ratings.</p> | Greg Tierney, MD, Chief Medical Officer and Medical Group President, Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |



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| 3/25/2019   | Peer Grouping          | <p>2. CMS should calculate a single Overall Hospital Quality Star rating based on peer groups of hospitals, and not all hospitals.</p> <p>With 332 licensed inpatient hospital beds, Benefis Health System provides a variety of inpatient and outpatient services for patients across our 38,000 square mile service area. We provide a comprehensive continuum of care services that includes acute care inpatient beds, long-term care, hospice, rural critical access hospital beds, assisted living, home health, durable medical equipment and many additional services. Providing safe, efficient, and effective care in these complex settings is difficult. Integrated care delivery is a critical tool for overcoming these challenges and helping Benefis Health System achieve cost-efficient, quality care throughout the region.</p> <p>In contrast, Great Falls Clinic Hospital is a 19 bed, for-profit, physician owned hospital located just a few blocks away from the BHS main campus. The Great Falls Clinic Hospital provides limited, non-trauma emergency services and does not have any critical care, intensive care, or specialized pediatric inpatient services. Patients presenting with chest pain, stroke symptoms, trauma and other critical issues are subsequently transferred three blocks to our emergency department via ambulance. Because they are a specialty/surgical hospital, they do report enough CMS quality metrics to receive an overall star rating. However, their overall patient demographics are vastly different than ours, especially since 76% of our payors are governmental.</p> <p>The mission and focus of for-profit specialty hospitals as compared to not-for profit, community owned health systems is vastly different, as are the acuity, complexity and payor mix of the people served. We support changes that improve the consumer's ability to compare like facilities when evaluating where to go for healthcare services. There are several important variables to consider in peer grouping, including but not limited to:</p> | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a> | Health System         | Please refer to the Summary Report |

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| 3/25/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>• Hospital size (beds);</li> <li>• Prospective Payment System (PPS) Hospitals versus Critical Access Hospitals (CAHs);</li> <li>• Patient complexity (i.e., dual eligibility, disproportionate share, predicted risk);</li> <li>• Number of individual measure reported per measure group;</li> <li>• For-profit versus not-for-profit status; and</li> <li>• Community versus private/physician ownership.</li> </ul>   | Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety<br>Benefis Health System                                      | <a href="mailto:juliewall@benefis.org">juliewall@benefis.org</a>                         | Health System          | Please refer to the Summary Report |
| 3/25/2019   | Peer Grouping          | <p>At the same time, I am concerned that, in your data analysis, all hospitals have been lumped together and I believe that the methodology of peer group comparisons should be considered. It is well documented that social determinants significantly impact patient outcomes. I believe that CMS inaccurately penalizes hospitals serving patients and their families with more challenging circumstances and who offer a full array of inpatient and outpatient services when they are compared to hospitals who serve a more defined population with selective targeted services . In essence, we see the results of comparing “apples to oranges”.</p> <p>We at FLH will continue our efforts to improve the care we deliver to a broad segment of a mostly rural population in Upstate New York. And we will focus our efforts on improving our patients’ and their families’ experience with us. In turn, may we ask you to consider the use of peer groups in your methodology for data analysis as a fair approach in creating “a level playing field”, Thank you.</p> | Ann McMullen   | <a href="mailto:jmcm@roadrunner.com">jmcm@roadrunner.com</a>                             | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Sharon Johnson, MBA, CPHQ, CPPS, Director of Quality Management, Utilization Management and Patient Safety; Highland Hospital of Rochester | <a href="mailto:Sharon_Johnson@URMC.Rochester.edu">Sharon_Johnson@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |

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| 3/26/2019   | Peer Grouping          | I support stratified ratings, which would allow hospitals to be compared to their peers. This information will be helpful for consumers, because it would enable more valid comparisons and increase the face validity of the rating system. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Pat Reagan Webster, PhD CPPS, Associate Quality Officer; Strong Memorial Hospital; Associate Professor, Public Health Sciences; University of Rochester | <a href="mailto:patricia_reagan@urmc.rochester.edu">patricia_reagan@urmc.rochester.edu</a> | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Peer Grouping          | -Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; proportion of dual-eligibles, and more consideration for hospitals that take in transfers from a large area / significantly greater percentage of transfer-ins than “peers”. No matter what the individual measure says about excluding based on admission status (because it is easy to flag in the data), the TRUE transfers are not just in that one field. They come in from another ED to clinic to ED, for example. From ED to ED (without an actual “hospital transfer”), etc. | Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital   Quality Management Dept.                          | <a href="mailto:scrimet@amc.edu">scrimet@amc.edu</a>                                       | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligible.   | Michele Walsh, MSN, RN, CNO; Ascension  | <a href="mailto:Michele.Walsh@ascension.org">Michele.Walsh@ascension.org</a>               | Individual             | Please refer to the Summary Report |
| 3/26/2019   | Peer Grouping          | • <b>Peer Grouping:</b> WHA strongly discourages peer grouping and the creation of multiple star ratings for a hospital. This multiplicity will complicate transparency and add unnecessary burden to the program. Hospital Compare lists an additional star rating for survey of patient experience data. Our members already contend with multiple star ratings, rankings, and best lists published by a variety of sources.  | Beth Dibbert, Chief Quality Officer, Wisconsin Hospital Association   | <a href="mailto:bdibbert@wha.org">bdibbert@wha.org</a>                                     | Hospital Association   | Please refer to the Summary Report |

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| 3/26/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Kathy Parrinello PhD, Executive Vice President and COO; Strong Memorial Hospital, University of Rochester Medical Center | <a href="mailto:Kathy_Parrinello@URMC.Rochester.edu">Kathy_Parrinello@URMC.Rochester.edu</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Daniel J. Baker, MD, MBA, Medical Director, Lenox Hill Hospital  | <a href="mailto:djbaker@northwell.edu">djbaker@northwell.edu</a>                             | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | <p>Accounts for potential biases. The ratings must account adequately for differences in the clinical and social risk factors across the patients and communities that hospitals serve. Hospitals that serve sicker and poorer patients should be on a level playing field with all other hospitals. The AHA has repeatedly noted that the current approach to ratings disadvantages hospitals caring for poorer communities and those like academic medical centers that tend to care for higher complexity patient.</p> <p>Peer grouping. The AHA believes CMS should continue to explore 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.</p> <p>To date, hospitals caring for sicker patients and poorer patients tend to fare worse on star ratings. Specifically, teaching hospitals, hospitals that report on larger numbers of star ratings measures, and hospitals receiving the highest disproportionate share hospital (DSH) payments (a proxy for the extent to hospitals serve the poor) all have ratings that are, on average, lower than other hospitals.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association              | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a>                                       | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>Peer grouping approaches attempt to create groupings of hospitals that are similar to one another on specific characteristics, comparing the performance of hospitals within those groupings. The basic notion is that it is fairer to compare hospitals that are similar to one another than it is to compare hospitals with very different characteristics. Furthermore, peer grouping is a viable approach to leveling the playing field in comparing hospital performance. Indeed, CMS already uses a peer grouping approach in its Hospital Readmissions Reduction Program (HRRP) by placing hospitals into peer groups based on the proportion of dual-eligible patients they treat. This has resulted in some lowering of penalties for those caring for the poorest communities.</p> <p>We believe CMS should continue to explore peer group stratification approaches as an interim step to improving the fairness of star ratings. The most promising variables to use in peer grouping should include those found to have an association to star ratings that are generally outside of the control of hospitals. These include the number of reported measures and the proportion of dual-eligible patients. CMS could consider peer groupings using only one of those two variables, or a peer grouping based on a composite of those two variables.</p> <p>At the same time, we strongly urge CMS to view peer grouping as an interim strategy while it assesses ways to improve the risk adjustment of the measures in star ratings. As we have noted with CMS's implementation of dual-eligible peer grouping in the HRRP, there are some inherent shortcomings with peer grouping approaches. The use of peer groupings involves somewhat subjective choices about where to set the cut points of a particular group. For example, those hospitals at the upper end of one group and those at the lower end of the next group would have similar proportions of dual-eligible patients, but would be placed into different groups for performance comparison purposes. Furthermore, direct risk adjustment would help improve the precision of performance comparisons by ensuring that measure scores reflect the issues most relevant to each measured outcome. For example, in peer grouping, one has to assume that dual-eligible status is as large a determinant of performance for readmissions as it is for hip and knee complications, when in fact, the impact of dual-eligible status may be slightly different for each measure.</p> | Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association | <a href="mailto:ademehin@aha.org">ademehin@aha.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Karen Carey, Interfaith Medical Center                           | <a href="mailto:KCarey@INTERFAITHMEDICAL.org">KCarey@INTERFAITHMEDICAL.org</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Kim Clement, Quality Analysis                                    | <a href="mailto:kclement@cmhhamilton.com">kclement@cmhhamilton.com</a>         | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.  | Sean Fadale, FACHE President and CEO Community Memorial Hospital | <a href="mailto:SFadale@Seancmhhamilton.com">SFadale@Seancmhhamilton.com</a>   | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. Stratifications should include considerations for teaching status, Critical Access Hospitals, urban/rural status, disproportionate share hospitals, case-mix index, patient volume variables, and proportion of dual-eligibles.   | Beth Falder, Health Quest  | <a href="mailto:bfalder@Healthquest.org">bfalder@Healthquest.org</a>           | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | I support stratified ratings, which would allow us to be compared to our peers. Working at a 21 bed, not-for-profit, community hospital, this is very important. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles. | Kathleen M Hebdon, MSN, RN, CDE                                  | <a href="mailto:KHebdon@bch-jbr.org">KHebdon@bch-jbr.org</a>                   | Individual             | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles. | Kurt Kodroff   | <a href="mailto:KKodroff@kingsbrook.org">KKodroff@kingsbrook.org</a> | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles. | Jacquel Kouns, MS, RN, NEA-BC, FACHE<br>Executive Director -<br>Montefiore Mount<br>Vernon<br>Vice President of<br>Clinical Services | <a href="mailto:JKOUNS@montefiore.org">JKOUNS@montefiore.org</a>     | Individual             | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles. | LuAnne Roberts   | <a href="mailto:lroberts@wcchs.net">lroberts@wcchs.net</a>           | Individual             | Please refer to the Summary Report |



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| 3/27/2019   | Peer Grouping          | <p>We have also advocated in favor of risk- adjustment for acute care patient transfers. These routine transfers pose a great challenge for UC Health's quality outcomes under the existing Star Ratings methodology. This is because patients who are transferred to academic medical centers, like UC Health, typically suffer from more severe, clinically exacerbated medical conditions beyond the clinically stable co-morbidities more characteristic of patients seen in community hospital settings. In spite of this reality, the Star Ratings system attributes outcomes for transfer patients to the main group of metrics by which UC Health and other academic medical centers are heavily evaluated. The Star Ratings system's failure to risk-adjust for patients' transfer status has the effect of penalizing UC Health's quality outcomes in the main hospital metrics categories of mortality and readmissions. The Star Ratings methodology's failure to account across all Star Rating measure groups for the externalities of the many vulnerable patient populations who rely uniquely on academic medical centers to provide their medical care results in undue reputational harm to safety net providers like UC Health. Without proper risk-adjustment or social-risk adjustment being applied to many of the main quality metrics by which the Star Ratings methodology evaluates academic medical centers, UC Health's medical centers risk CMS communicating misleading information to the public about our hospitals' true quality of care. Such an effect could compromise potential patients' decision-making and their access to necessary medical services.</p> | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System         | Please refer to the Summary Report |



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| 3/27/2019   | Peer Grouping          | <p>Measure Precision</p> <p>UC Health recognizes that the current Star Ratings methodology employs measure denominator weighting to account for differences in measure score precision, so that hospitals and measures with a larger denominator are more heavily weighted in each Latent Variable Modeling (LVM). This results in hospitals being scored more heavily on measures that include more patients in the denominator. As academic medical centers that are uniquely tertiary and quaternary care providers, with the use of the LVM method, the measures most heavily weighted for UC Health and our peers reflect the higher complexity services and higher acuity patients we typically treat in comparison to community hospitals, which are many patients' first point of care. For example, a community hospital is likely to be more heavily weighted on a pneumonia measure given it is the appropriate setting for treating more patients suffering from pneumonia. As leading academic medical centers and safety net providers for California, we have larger denominators for measures associated with the more complex medical services we provide. These complex services include, but are not limited to, providing organ transplants, performing complex surgeries, providing burn care, and providing life-sustaining treatment to many patients suffering from advanced stage cancer.</p> <p>UC Health does not think an "apples to apples" comparison can be made between the measures for which our medical centers have the highest denominators and the measures by which non-teaching hospitals or non-safety net provider hospitals have the largest denominators. We have expressed concern that the current Star Ratings methodology rewards community hospital settings by omission. In other words, the measures for the medical services they either do not perform, or perform very little, provide little to no weight in their overall Star Rating component score. However, by virtue of being both safety net providers and last points of care for some of the country's sickest patients, UC Health's five academic medical centers have great weight attributed to many of the measures representing the complex medical conditions which they uniquely treat.</p> | John Stobo, MD,<br>Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System         | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | Given the reality that across our system 60 percent of our patients are publicly insured or uninsured, weighting by large denominators cannot be near precise without also including much social-risk adjustment for the sociodemographic factors unique to the vulnerable populations our hospitals typically treat. CMS states that it has surveyed the current Overall Hospital Quality Star Rating measures and found that those in the outcome groups of Mortality, Readmission, and Safety of Care include some adjustment for precision by accounting for volume in the score itself, while measures in the four remaining measure groups of Patient Experience, Effectiveness, Timeliness, and Imaging Efficiency have no such adjustment. We request that social-risk adjustment for patients' sociodemographic factors must occur across all of these measure groups. | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System          | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | 2) Allow for adjustment of socio-demographic factors of patients for the Star Ratings system's measure groups.<br>3) Apply Star Ratings on a peer group basis, so that hospitals are compared to similarly situated hospitals. A great flaw of the existing methodology is that academic medical centers cannot, and should not, have their quality metrics directly compared with other categories of hospitals, like community hospitals, which have totally different functions. By virtue of our teaching, research, and safety net missions, UC Health and our academic medical center peers routinely treat more highly acute and vulnerable patient populations than community hospitals.  | John Stobo, MD, Executive Vice President, University of California Health System | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a> | Health System          | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | UC Health urges CMS to calculate and present Overall Hospital Quality Star Rating results in a way that compares hospitals of a similar type, that treat similar populations, to each other. We think so-called peer grouping better accounts for the distinctions of various hospital types, as well as better informs consumers of what to expect from a given hospital. As earlier referenced in this letter, the mission of a teaching hospital, and in turn the population it is prepared to treat, is wholly different from the mission and work of other hospital types. We think peer grouping will result in less confusion for consumers and patients. We would request that academic medical centers be segregated from other hospital types when comparing quality metrics data and calculating a hospital's Star Rating. We also think consumers and patients will better understand the nature of UC Health's roles as teaching hospital, safety net and tertiary and quaternary care provider by assigning it to a peer group with other teaching hospitals, as well as specifically teaching hospitals that see a high percentage of patients dually eligible for Medicaid and Medicare. Our peer academic medical centers have also previously requested that we be compared to each other and segregated from being viewed against other non-academic medical center hospitals whose Star Rating is published on the Hospital Compare Website. We would request that in addition to being compared to other peer academic medical centers, our Star Ratings be presented on the Hospital Compare website alongside with other academic medical centers' individual Star Ratings. | John Stobo, MD, Executive Vice President, University of California Health System           | <a href="mailto:Julie.Clements@ucdc.edu">Julie.Clements@ucdc.edu</a>                     | Health System          | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Peer Grouping: CMS would like feedback from the public regarding the value of calculating the Overall Hospital Quality Star Rating based on peer groups of hospitals, and if so, how the information should be displayed. We support CMS exploring the use of peer grouping. We recommend that the peer groups be defined in a way that makes sense to the general public and the differences between the groups. We also believe that when searching for a specific hospital facility on the compare.gov website, it is visually clear to the general public which group each facility falls under.   | Angela A. Shippy, MD, FACP, FHM SVP & Chief Quality Officer Memorial Hermann Health System | <a href="mailto:Angela.Shippy@memorialhermann.org">Angela.Shippy@memorialhermann.org</a> | Health System          | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | In response to previous requests for feedback, we shared our position that peer-group stratification of the Overall Star Ratings is needed to achieve any chance of parity and equity as a basis for comparing health care providers and demonstrating a meaningful basis of comparison for consumers. While we recognize that stratification introduces at least some degree of additional complexity, the experience of observing consumer behavior and decision-making across numerous industries (education, automobile, hospitality and restaurant to name a few) demonstrates consumers' ability to recognize the importance of classification to make meaningful quality comparisons. We believe that if relevant peer-grouping designations are incorporated and presented with clear definition of the grouping criteria, consumers will value and embrace the information.   | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | Before the July 2016 release of the Centers for Medicare & Medicaid Services hospital star ratings, a majority in Congress and many industry leaders voiced concerns about the equity of the methodology. <sup>1</sup> At that time, evidence suggested that the rating system could adversely and disproportionately impact safety-net hospitals and large hospitals electing to report additional measures. Before the release of the star ratings, we encouraged CMS to refine the body of measures designed to provide health care consumers with meaningful hospital quality data. At the same time, we questioned the premise of whether the myriad dimensions of hospital quality could effectively be reduced into a simple five-point scale. Release of the hospital star ratings allowed a much more comprehensive analysis of the data. Regrettably, we found that methodology — specifically, its lack of recognition of the relationship between social determinants of health and adverse health outcomes—reaffirmed our concerns. We are certain that the goal of CMS officials, and other U.S. Department of Health and Human Services stakeholders, is not to disadvantage safety-net providers or hospitals that have robust reporting programs. In fact, CMS and HHS officials are on record on the matter. | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>Cara James, Ph.D., Director of CMS’ Office of Minority Health, recently stated that as much as 80 percent of health disparities are driven by social determinants of health, and that structural barriers are in place to prevent the health care system from effectively addressing these conditions.<sup>2</sup> Moreover, a January 2016 report commissioned by OMH, “Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries,” acknowledges higher readmission rates for socially complex patients that are not explained by clinical differences.<sup>3</sup></p> <p><sup>2</sup>This suggests that two hospitals of equal quality, but unequal sociodemographic-status mix, will experience different penalties under the Hospital Readmission Reduction Program — a significant factor in the star ratings model.</p> <p>CMS also has signaled its understanding of the influences of social determinants in quality measurement programs for managed care plans. For example, the Medicare Advantage star-rating incentive program began being risk-adjusted for differences in dual eligibility and disability status in fiscal year 2017.<sup>4</sup></p> <p>Given the financial and reputational considerations, we analyzed the star rating data supplied by CMS and Yale-CORE. Our goal was to evaluate variation in the star ratings by hospital characteristics, including the socioeconomic status of hospitals' ZIP codes, and ,to characterize the impact of certain assumptions and components of the measure set. The research focused on two significant considerations - whether safety-net hospitals' ratings would be influenced by SDS adjustment and whether case complexity and robust surveillance could bias ratings.</p> <p>The analysis yielded clear evidence of a systematic relationship between the number of stars awarded and SDS factors at both the hospital ZIP code and patient case-mix levels, and between the number of measures reported and domains used in the models. We also uncovered evidence of the model's extreme sensitivity to measures with questionable validity <sup>5</sup> and measures presenting redundant constructs within the readmissions domain. <sup>6</sup> Detailed results are included in the attachment, but a high-level review reveals the following.</p> | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>There is a 277 percent difference in a standard socioeconomic deprivation index for the home ZIP codes of one-star and five-star hospitals nationally. Differences in race, poverty and educational attainment are significant in the home ZIP codes of one-star and five-star hospitals. Compared to five-star hospitals, one-star providers had significant differences in supplemental security income ratio, disproportionate share hospital percentage and uncompensated care.</p> <p>On average, one-star hospitals reported 50.4 measures in 6.6 domains. This is 39.3 and 15.2 percent higher than five-star hospitals, respectively.</p> <p>Given the challenges presented in these findings, we would urge that as the new administration reviews this issue, CMS should work with stakeholders to further evaluate and refine the star rating system. The continued promulgation of quality measures that adversely impact hospitals serving indigent communities is a practice CMS should reverse.</p> <p>1 Letter to Acting Administrator Andy Slavitt from Congress (2016). Retrieved from <a href="http://www.aha.org/advocacyissues/letter/2016/160331-stardearcolleague.pdf">http://www.aha.org/advocacyissues/letter/2016/160331-stardearcolleague.pdf</a>.</p> <p>2 Modern Healthcare. (2016, April 23). Q&amp;A: Building the business case for achieving health equity. Retrieved from <a href="http://www.modernhealthcare.com/article/20160423/PODCAST/304239941">http://www.modernhealthcare.com/article/20160423/PODCAST/304239941</a>.</p> <p>3 Betancourt, J., Tan-McGrory, A. &amp; Kenst, K.. (2015, September). Guide to preventing readmissions among racially and ethnically diverse Medicare beneficiaries. Prepared by the Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital. Baltimore, MD: Centers for Medicare &amp; Medicaid Services Office of Minority Health.</p> <p>4 U.S. Centers for Medicare &amp; Medicaid Services. (2016, April 4) 2017 rate announcement and call letter. Retrieved from <a href="https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf">https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf</a>.</p> | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>5 Rajaram R, Barnard C, Bilimoria, KY. Concerns About Using the Patient Safety Indicator-90 Composite in Payfor-Performance Programs. JAMA.2015;313(9):897-898. doi:10.1001/jama.2015.52. Retrieved from <a href="http://jama.jamanetwork.com/article.aspx?articleid=2109967">http://jama.jamanetwork.com/article.aspx?articleid=2109967</a>.</p> <p>6 Vella, F. (2016) Comment Letter Prepared for the American Hospital Association. Retrieved from <a href="http://www.aha.org/content/16/16georgetownmeas.pdf">http://www.aha.org/content/16/16georgetownmeas.pdf</a></p>   | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association  | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | <p>MISSOURI HOSPITAL ASSOCIATION ANALYSIS OF THE CMS OVERALL HOSPITAL QUALITY STAR RATING METHODOLOGY BACKGROUND</p> <p>The Missouri Hospital Association conducted a series of analyses to explore the hypotheses voiced by numerous concerned stakeholders prior to the July 2016 Hospital Overall Star Ratings data release. Using the data and SAS packages supplied by CMS and Yale-CORE, we sought to evaluate variation in the star ratings by hospital characteristics, including the sociodemographic status of the ZIP codes in which hospitals are located. We sought to test the sensitivity of the star rating models to key measures, assumptions and inclusion criteria used by the measure developers.</p> <p>BIVARIATE ANALYSIS</p> <p>The two most common critiques of the star ratings prior to their release were: hospitals that serve less-advantaged communities would be disproportionately ranked unfavorably because the underlying outcome measures are not adjusted for SDS1,2; and similarly that larger hospitals would fare less favorably because they treat the most complex cases, have more robust surveillance systems and report on more of the measures used by the star rating model.</p> | Herb B. Kuhn, President, CEO, Missouri Hospital Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/27/2019   | Peer Grouping          | <p>3.Our analysis yielded clear evidence of a systematic relationship between the number of stars awarded and SDS factors at both the hospital ZIP code and patient case-mix levels <a href="#">[Table 13]</a>. Many of the area-level SDS factors we evaluated share a monotonic relationship with the number of stars awarded in the direction previously hypothesized by opponents of the overall quality rating system. For example, there is a 277 percent difference in a standard socioeconomic deprivation index for the home ZIP codes of one- and five-star hospitals nationally. One-star rated hospitals, on average, are located in ZIP codes that are 46 percent nonwhite and 17.6 percent of the adult population holds less than a high school education, compared to five-star hospitals with home ZIP code populations that are 24 percent nonwhite and 9 percent of adults have less than a high school education (a difference of 91 and 92 percent, respectively).</p> <p>Compared to five-star hospitals, one-star providers had nearly four-fold differences in both Supplemental Security Insurance ratio and disproportionate share hospital percentage. Another indicator of the social and economic contextual surroundings of hospitals’ patients is the average amount of uncompensated care per claim — a signal of un- and underinsured payer mix. One-star hospitals faced an average \$3,801 in uncompensated care per claim compared to just \$170 for five star hospitals — a 22-fold difference. The concern over systematic bias for larger hospitals also garners empirical support from the data. While it is not clear to us why a cut point of three out of seven domains with a minimal level of representation by outcomes measures was used as the reporting threshold, we question why measure values from hospitals below this threshold were retained in the derivation of the ratings. Regardless of the rationale, a significant relationship appears to exist between the number of stars awarded and both the number of reported measures (of 64) and number represented domains (of seven) used in the latent variable models. This potentially is an artifact of the weighted likelihood approach that increases factor loadings for measures with larger denominators. On average, one-star hospitals reported 50.4 measures in 6.6 domains. This is 39.3 and 15.2 percent higher than five-star hospitals, respectively <a href="#">[Table 14]</a>. Further, measures of volume, urbanity and case complexity each share a near-monotonic inverse relationship with the number of stars awarded.</p> | Herb B. Kuhn,<br>President, CEO,<br>Missouri Hospital<br>Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital<br>Association | Please refer to the<br>Summary Report |



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| 3/27/2019   | Peer Grouping          | <p>SENSITIVITY ANALYSIS</p> <p>We analyzed the sensitivity of the latent variable models to the arbitrary inclusion or exclusion</p> <ul style="list-style-type: none"> <li>• of measures by:</li> <li>• limiting the data to hospitals with all seven domains represented</li> <li>• testing the model's sensitivity to the exclusion of particular measures with questionable methods<sup>4</sup>, and/or questionable unidimensionality<sup>5</sup> (PSI-90 and HWR, respectively)</li> <li>• testing the model's sensitivity to domain completeness with PSI-90 and HWR excluded.</li> </ul> <p>MHA compared the results of the sensitivity tests with the base CMS model in terms of the prevalence of changed star designations for hospitals and calculated measures of interrater reliability (Kappa statistic). Compared to the base CMS model, the complete domain model added one star to nearly onethird (871, 29.1 percent) of all hospitals with seven domains represented, while surprisingly deducting stars from none. The complete domain model also featured modest agreement with the base CMS model (Kappa = 0.57), suggesting the models are very sensitive to the arbitrary inclusion or exclusion of domains and underlying measures [Table 15]. Our findings also show that the star ratings are extremely sensitive to the exclusion of methodologically questionable and potentially repetitive individual measures. Excluding PSI- 90 from the safety of care domain changed the star designations for 1,350 hospitals (29.7 percent), with the majority having a star taken away. Removing the single PSI-90 measure yielded results with limited agreement with the base CMS model (Kappa = 0.52). The models were less sensitive to the exclusion of HWR individually, with 15.1 percent of hospitals changing star designations and moderate agreement with the original ratings (Kappa = 0.75). The final sensitivity test was limited to hospitals with seven domains, and excluded both the PSI-90 and HWR measures. Imposing these assumptions changed the star designation of 36.8 percent of included hospitals with a range of two stars lost to three stars gained.</p> | Herb B. Kuhn,<br>President, CEO,<br>Missouri Hospital<br>Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>This approach also revealed very limited agreement with the base CMS model (Kappa = 0.45), suggesting strong sensitivity of the existing measures to the modifications we tested and raising questions on the reliability of the measures. Additional analysis is needed to identify hospital characteristics associated with positive and negative impacts from the results of these sensitivity tests.</p> <p>References:</p> <p>1 Letter to Acting Administrator Andy Slavitt from Congress (2016). Retrieved from <a href="http://www.aha.org/advocacyissues/letter/2016/160331-stardearcolleague.pdf">http://www.aha.org/advocacyissues/letter/2016/160331-stardearcolleague.pdf</a>.</p> <p>2 Letter to Acting Administrator Andy Slavitt from the Missouri Hospital Association (2016). Retrieved from <a href="http://www.mhanet.com/mhaimages/SlavittLetter.pdf">http://www.mhanet.com/mhaimages/SlavittLetter.pdf</a>.</p> <p>3 American Association of Medical Colleges (2016). Star Ratings “Deeply Flawed,” Offer Incomplete Picture of Performance. Retrieved from <a href="https://www.aamc.org/newsroom/newsreleases/464306/20160727_starratingsrelease.html">https://www.aamc.org/newsroom/newsreleases/464306/20160727_starratingsrelease.html</a>.</p> <p>4 Rajaram R., Barnard, C. Bilimoria, K. (2015) Concerns about using the patient safety indicator-90 composite in payfor-performance programs. JAMA; 313(9):897-898. doi:10.1001/jama.2015.52. Retrieved from <a href="http://jama.jamanetwork.com/article.aspx?articleid=2109967">http://jama.jamanetwork.com/article.aspx?articleid=2109967</a>.</p> <p>5 Vella, F. (2016) Comment Letter Prepared for the American Hospital Association. Retrieved from <a href="http://www.aha.org/content/16/16georgetownmeas.pdf">http://www.aha.org/content/16/16georgetownmeas.pdf</a>.</p> | Herb B. Kuhn,<br>President, CEO,<br>Missouri Hospital<br>Association | <a href="mailto:DLandon@mhanet.com">DLandon@mhanet.com</a> | Hospital<br>Association | Please refer to the<br>Summary Report |

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| 3/27/2019   | Peer Grouping          | <p>Social Determinants of Health</p> <p>As one of the nation's largest public health systems, CCH provides care to many of the region's most vulnerable residents. A disproportionate share of our patients struggle with poverty, insecure housing, inadequate access to nutritious foods, and regular exposure to violence and trauma. These struggles constitute patients' social determinants of health: factors which negatively impact their health outcomes but lie mainly out of CCH's control. Yet CCH worries that CMS's Star Rating - which relies on such outcome measurements as readmission rates, mortality rates, and patient experience performance - fails to adjust for the negative impact that our patient population's socioeconomic barriers have on health outcomes. Without such an adjustment, the Star Rating methodology puts hospitals caring for poor communities at an unfair disadvantage, and misleads consumers. CCH believes that CMS should adopt measures that adjust for patients' sociodemographic status - for instance by bringing them in line with those used by the Hospital Readmissions Reduction Program.</p> | John Jay Shannon, CEO, Cook County Health   | <a href="mailto:joshua.mark@cookcountyhhs.org">joshua.mark@cookcountyhhs.org</a> | Health System          | Please refer to the Summary Report |
| 3/27/2019   | Peer Grouping          | <p>CCH believes that assigning hospitals to peer groups based on their size or status like teaching or community hospital would be beneficial both to hospitals and to potential patients attempting to use the Overall Star Rating. Peer grouping holds promise as comparisons with 'like-me' hospitals provide a more accurate assessment of hospital performance &amp; opportunity. It is true that despite leveraging Hospital Peer Grouping for the Readmission Reduction Program, CMS received feedback that hospital groupings could potentially be confusing. Generally speaking, patients are unfamiliar with 'Safety Net', 'Complex Teaching' or 'AMC' designations, for instance. Nevertheless, until a more comprehensive clinical condition assessment with adequate risk adjustment is available, Hospital Peer Grouping will continue to be needed.</p>   | John Jay Shannon, CEO, Cook County Health   | <a href="mailto:joshua.mark@cookcountyhhs.org">joshua.mark@cookcountyhhs.org</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Peer Grouping          | <p>Hello my comments are as follows:</p> <p>Group hospitals by type, for example safety net hospitals, % Medicaid and type of community, by region- upstate versus downstate in New York.</p>  | Maureen Eisner, Vice President of Patient Experience and Bioethics, SBH Health System | <a href="mailto:meisner@sbhny.org">meisner@sbhny.org</a>                         | Individual             | Please refer to the Summary Report |

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| 3/28/2019   | Peer Grouping          | We believe that the current Hospital Quality Star Rating system does not have adequate risk adjustments for patient socioeconomic and sociodemographic factors nor for the complexity of care provided by TUH and most other Academic Medical Centers (AMCs) across the country. In this regard, we recommend a major overhaul of the Hospital Star Rating System with another prolonged pause in publication.  | Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital<br>Henry Pitt, MD, Chief Quality Officer, Temple University Health System | <a href="mailto:henry.pitt@tuhs.temple.edu">henry.pitt@tuhs.temple.edu</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Peer Grouping          | We further recommend that CMS develop ways to account for difference among hospitals with respect to both the patients served and the complexity of services that are provided .<br>Specifically, CMS should adopt methodologies to risk-adjust for patient social determinants of health. Insecurities with respect to food, housing and transportation as well as disparities in race, ethnicity, language and education all have been demonstrated to adversely influence readmissions as well as patient safety indicators (PSIs) and patient satisfaction. In addition, as more complex services are provided, readmissions, PSIs, patient satisfaction and length of stay all are adversely affected. Thus, risk-adjustment for complexity also is imperative.<br><br>The proposed potential adjustments for measure number, teaching status, number of beds, dual eligibility or critical access all have some merit. However, none adequately adjust for safety- net mission or hospital complexity. As an interim step toward true risk adjustment, we could support a “blended peer group methodology” which would include teaching status, measures and/or bed number as well as critical access status. | Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital<br>Henry Pitt, MD, Chief Quality Officer, Temple University Health System | <a href="mailto:henry.pitt@tuhs.temple.edu">henry.pitt@tuhs.temple.edu</a> | Health System          | Please refer to the Summary Report |
| 3/28/2019   | Peer Grouping          | However, a new algorithm will need to be developed in order to provide current risk-adjusted data that accounts for socioeconomic issues and a fair alignment to other like-volume/size facilities providing the same services.   | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center   | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a>                   | Health System          | Please refer to the Summary Report |

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| 3/28/2019   | Peer Grouping          | Peer grouping to comparable hospitals could be achieved if the scoring was used with risk-adjusted data that accounts for socioeconomic and poverty issues as well as a fair alignment to other like-volume/size facilities providing the same services. One observation, in the recent release of ratings, is the consistent bell-curve result in states which provide questions and concerns with the distribution of star ratings. Currently, AHA's research indicated that hospitals located in lower socioeconomic areas will ultimately fall within a CMS 1- to 3-star scoring range; this bias provides a defect in the scoring. It also indicates that the HCAHPS scoring will create an artificial ceiling in performance due to lower socioeconomic status even with aggressive quality improvements in place. Currently, one small discrepancy in data can make a huge impact on the whole result. Peer grouping should showcase adjustments including size, volume, socioeconomic status impact, services provided and not provided, and measure submissions/exclusion of measure submissions. Currently, this is not the case, and the star rating provides a false picture to the public. The star rating could cast an unfair shadow over a hospital which could provide more fuel for trolling and business bullying. | Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center | <a href="mailto:kdonaghy@wmhs.com">kdonaghy@wmhs.com</a> | Health System         | Please refer to the Summary Report |

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| 3/28/19     | Peer Grouping          | <p><b>4.5 Peer Grouping Questions for the Public:</b></p> <p>1. Would it be valuable to calculate Overall Hospital Quality Star Ratings among peer groups? <b>Yes.</b> How should the information be displayed? <b>Overall Star Rating and a Peer Group Rating both textually and graphically. Including a simple definition of groupings that is understandable to the lay public is also important here. This information should be displayed similar to benchmark data (State/National).</b> If CMS decides to move forward with this feature, which stakeholders do you believe would use the information and how would they use it? <b>Hospitals, payors, and patients. It would be useful for comparative purposes as well as quality improvement</b></p> <p>2. Among the feasible variables that could be used for peer grouping (specialty, number of measures reported, teaching status, number of beds, critical access hospital, proportion of dual eligible patients), which would be most useful? <b>Displaying by specialty would give the most appropriate and accurate clinical comparisons. Although teaching status has been mentioned as a proxy for recognizing potential social disparities in patient populations, there are many non-teaching hospitals that also serve a large number of patients in this patient population. Using teaching status alone would not necessarily capture or represent these differences accurately. Bed size may also be useful in that it may more accurately represent the types of services offered at similar facilities and therefore may better represent similar patient populations.</b></p> | Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health | <a href="mailto:mbrowne@covhlth.com">mbrowne@covhlth.com</a> | Health System          | Please refer to the Summary Report |

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| 3/28/19     | Peer Grouping          | <p>While one measure across all hospitals is ideal, this is not practical and fair to all hospitals. Hospitals are not homogenous. A hospital's size, location, specialties, teaching designation, and a number of other factors influence the types of patients a hospital cares for. The types of patients a hospital receives contributes to their outcomes to the point where they cannot be judged evenly across all hospital without full, perfect risk adjustment. Since perfect risk adjustment is not reasonable, the creation of cohorts based on teaching status (as done with Vizient annual rankings), size, or socioeconomic status (as done in HRRP) are preferred. We agree that providing multiple star ratings for each hospital would be confusing for consumers. CMS should just clearly state on Hospital Compare which cohort each hospital belongs to.</p> <p>The volume adjustments built into the underlying measures by the Hierarchical Logistic Regression models are causing biases in star distribution based on hospital size. The following chart <a href="#">[Figure 7]</a> shows the distribution of stars based on hospital size during the Feb 2019 release. (Hospital size was proxy'ed by the denominator of the HWR measure.) Creating cohorts with hospital size as a factor should help reduce these biases.</p> <p>Cohorts based on socioeconomic status (SES), specifically proportion of dual eligible status, was mentioned in the Public Input Request document. This would align the Overall Rating with the Hospital Readmission Reduction Program and the mandate for SES inclusion from the 21st Century Cures Act. If creating cohorts based on SES are undesirable, SES should be included as a risk-adjustment factor in the domain models.</p> <p>The following chart <a href="#">[Figure 8]</a> shows the distribution of stars by the HRRP SES cohorts during the Feb 2019 release. Biases in the distribution of stars based on SES cohorts are clearly shown.</p> <p>These biases in distribution of stars cannot continue in the CMS Overall Rating program. Winners and losers should not be determined based on a hospital's size and location.</p> | <p>Dr. Omar Lateef<br/>Stuart Levin, MD<br/>Presidential Professor of Rush University<br/>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br/>Rush University Medical Center<br/>Chicago, Illinois</p> <p>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine</p> <p>Thomas A. Webb, MBA<br/>Manager, Quality Improvement; Rush University Medical Center</p> | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University     | Please refer to the Summary Report |

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| 3/28/19     | Peer Grouping          | Finally – there should be an alignment of the Socioeconomic Status (SES) adjustment used in the HRRP program and the stars program. Introducing risk adjustment in the stars readmission measure would seem to be the most straightforward approach. The current approach in which there is a discordance between the programs is confusing for hospitals and further contributes to the potential bias. | Dr. Omar Lateef<br>Stuart Levin, MD<br>Presidential Professor of Rush University<br>Professor, Critical Care Medicine Senior Vice President and Chief Medical Officer;<br>Rush University Medical Center<br>Chicago, Illinois<br>Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO   Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine<br>Thomas A. Webb, MBA<br>Manager, Quality Improvement; Rush University Medical Center | <a href="mailto:Thomas_A_Webb@rush.edu">Thomas_A_Webb@rush.edu</a> | Medical University    | Please refer to the Summary Report |



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| 3/28/2019   | Peer Grouping          | <p>Spectrum Health is concerned that the hospital star ratings, in their current form, may be unfairly masking quality or, possibly, over-weighting of patient experience measures and will therefore not help consumers make well-informed decisions about which hospitals to use. A number of the quality measures that underpin the ratings unfairly impact teaching hospitals that treat low socioeconomic status patients, more complex patients, and perform a greater number of complicated surgeries. The Medicare Payment Advisory Committee (MedPAC), the National Quality Forum, and other researchers have underscored the importance of appropriately adjusting for socioeconomic status and patient complexity; and CMS has recognized the need for this adjustment in the Medicare Advantage and Medicare Part D programs.</p> <p>CMS is considering changing the way that each measure's and hospital's scores precision are weighted within the statistical model. Right now, CMS uses, roughly, the number of patients that are part of each quality measure to determine the contribution or weight of that quality measure. As CMS considers alternative approaches to support more balanced contributions of measures within a group, we ask that the agency consider past experience with the Emergency Department Throughput Measures. It's essential to compare like with like. If measures in the group have different benchmarks, a hospital could have top decile performance, but lower volumes.</p> <p>Performance needs to be replicable and simple to understand, so hospitals can determine their own performance during the reporting period, especially because the data is lagging. If the agency selects a peer groupings approach, it should ensure like to like comparisons. However, if the peer groups do not consist of like to like comparisons then we recommend CMS institute a severity adjusted, hospital type, patient type and volume like to like comparison.</p> | <p>Leslie M. Jurecko MD, MBA<br/>SVP, Quality, Safety, and Experience<br/>Spectrum Health<br/>Pediatric Hospitalist<br/>Assistant Professor of Pediatrics at Michigan State University,<br/>College of Human Medicine</p> | <p><a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a></p> | Hospital              | Please refer to the Summary Report |

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| 3/28/2019   | Peer Grouping          | CMS would like feedback from the public regarding the value of calculating the Overall Hospital Quality Star Rating based on peer groups of hospitals, and if so, how the information should be displayed. Spectrum Health recommends CMS provide hospitals with their overall and peer groupings calculations. However, only one scoring approach should be made publicly visible to ensure that the information is simple and easy to understand for engagement.   | Leslie M. Jurecko MD, MBA<br>SVP, Quality, Safety, and Experience<br>Spectrum Health<br>Pediatric Hospitalist<br>Assistant Professor of Pediatrics at Michigan State University,<br>College of Human Medicine | <a href="mailto:Leslie.Jurecko@spectrumhealth.org">Leslie.Jurecko@spectrumhealth.org</a>                 | Hospital                 | Please refer to the Summary Report |
| 3/28/2019   | Peer Grouping          | <p>•Peer Grouping: The AAMC remains supportive of peer grouping and believes stratified comparisons are useful to patients and consumers to best understand the different types of hospitals available to them, especially as a short-term solution to the broader need to develop more rigorous risk adjustment at the measure-level. We urge CMS to ensure that stratified comparisons of hospital performance are clear when published on Hospital Compare.</p> <p>CMS seeks feedback on the value of and ways it should calculate Overall Quality Star Ratings among peer groups, in an effort to present the ratings results based on hospitals that “look like them.” As currently implemented, CMS compares all hospitals that meet the minimum measure requirements (nine measure scores, across a minimum of group measure groups, with at least one measure group related to outcomes) regardless of differences in hospital characteristics, such as teaching or safety-net status, number of beds, or range of services provided. Teaching hospitals perform a wide array of complicated and common procedures, pioneer new treatments, and care for broader socio-demographic patient populations that may have limited access to care. Yet under the current Star Ratings program, they are compared directly to hospitals with homogenous patient populations and hospitals that do not perform enough procedures to be measured on a majority of the individuals included in the methodology. This had led to observations that the ratings disadvantage large teaching hospitals.</p> | Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer   | <a href="mailto:galee@aamc.org">galee@aamc.org</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Peer Grouping          | <p>The AAMC has consistently supported peer grouping as a way to stratify the ratings by hospital type or characteristic, and has previously recommended that CMS explore measure performance within specific hospital peer cohorts so that hospitals with similar characteristics and risk profiles are compared to each other. The AAMC supports peer grouping and believes stratified comparisons are useful to hospital stakeholders for quality improvement activities and also to help patients and consumers best understand differences among the various types of hospitals available to them. CMS's Nursing Home Compare Star Ratings and Star Ratings for Medicare Advantage and Part D plans, in addition to the Veteran's Affairs Strategic Analytics for Improvement and Learning (SAIL) Hospital Star Ratings, account for differences in cohort being compared. The AAMC believes that CMS should look to these programs to inform peer grouping in the Overall Hospital Quality Star Ratings. The AAMC asks that CMS consider multiple stratification approaches and share analysis or data simulation of different approaches, to help inform stakeholder feedback.</p> <p>Variables</p> <p>CMS seeks feedback on the variety of variables it could use for peer grouping (proportion of dual- eligible patients, number of measures reporting, teaching status, number of beds, specialty, critical access hospital, for example) and which of those would be most useful. The AAMC understands that each variable may have advantages and disadvantages, and that no one variable for peer grouping will address the lack of adequate risk adjustment to account for SDS factors. We recommend that, until a more refined methodology is available, CMS stratify by either social risk, using proportion of dual-eligible patients similar to the peer grouping implemented in the Hospital Readmission Reduction Program for symmetry, or by hospital size/full service status, to ensure patients are able to compare hospitals that are able to fully meet their care needs. Regardless, the AAMC asks CMS to implement peer grouping as a short-term solution while it addresses the broader need to develop more rigorous risk adjustment at the measure-level. CMS should conduct a thorough analysis of the extensive data it has available to determine the most appropriate peer groups.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer | <a href="mailto:galee@aamc.orgpr">galee@aamc.orgpr</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |

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| 3/28/2019   | Peer Grouping          | <p>Presentation of Peer Grouping</p> <p>CMS notes that there is disagreement among stakeholders on how peer grouping would be presented on the Hospital Compare website. In particular, some stakeholders believe that peer grouped results would be confusing and unhelpful to patients and consumers and thus peer grouped results should be presented as supplemental information to the unstratified Overall Hospital Quality Star Rating. The AAMC disagrees that such information is confusing or unhelpful. Instead, we believe patients should be able to discern the range of services available at any particular hospital, and whether that hospital has reported measures of importance to the patient. As currently presented, a patient might not be able to distinguish whether the “top rated” hospital in the patient’s region is a community hospital that may be unable to care for patients with more complex conditions. Presenting the peer grouped ratings within the web-based tool when a patient searches for hospitals will assist that patient in better understanding the options available. The AAMC urges CMS to ensure that stratified comparisons of hospital performance are clear when published on Hospital Compare.</p> | Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer  | <a href="mailto:galee@aamc.org">galee@aamc.org</a><br><a href="mailto:amsey@aamc.org">amsey@aamc.org</a> | Professional Association | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p>Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.</p>  | Sameh Samy, MBBCh, MSA, CPHQ, AVP, Quality Management Dept., Maimonides Medical Center               | <a href="mailto:APollack@maimonidesmed.org">APollack@maimonidesmed.org</a>                               | Hospital                 | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p>We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, which we believe have had a significant negative bias on our hospital ratings, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.</p>  | William Lynch, Executive Vice President and Chief Operating Officer, Jamaica Hospital Medical Center | <a href="mailto:BFLANZ@jhmc.org">BFLANZ@jhmc.org</a>   | Hospital                 | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles. Others to consider in addition to size, and complexity of provider services are geographical location and payer mix. | Sharon L. Narducci<br>DNP, APRN-BC,<br>CCRN, Chief Quality Officer, Jamaica Hospital Medical Center, Flushing Hospital Medical Center | <a href="mailto:SNARDUCC@jhmc.org">SNARDUCC@jhmc.org</a>                                     | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <b>4. Peer Grouping:</b> CMS should continue to test the use of risk adjustments to apply appropriately to hospitals to level the playing field and provide one adjusted star rating for each hospital.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer; Advocate Aurora Health   | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a>   | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <b>4. Peer Grouping</b><br>Advocate Aurora strongly discourages peer grouping and the creation of multiple star ratings for a hospital as it would prove to be confusing for consumers and patients. We feel that CMS should continue to test the use of risk adjustments (bed size, safety net status, teaching status, dual eligibility/disproportionate care, etc.) to apply appropriately to hospitals to level the playing field and provide one adjusted star rating for each hospital.   | Gary Stuck, DO<br>FAAFP,<br>Chief Medical Officer; Advocate Aurora Health   | <a href="mailto:Shauna.Mccarthy@advocatehealth.com">Shauna.Mccarthy@advocatehealth.com</a>   | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We believe the Star Rating does not stratify the measures to put hospitals in like cohorts even though the CMS pay-for-performance programs have already implemented stratified comparison. For example, the readmission reduction program uses a stratified score for five hospital cohorts to account for socioeconomic issues that impact safety-net hospitals.  | George V. Masi,<br>President and CEO; Harris Health System  | <a href="mailto:Elizabeth.Greenlee@harrishealth.org">Elizabeth.Greenlee@harrishealth.org</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We believe the Star Rating does not risk adjust data to take our patient's socioeconomic and demographic circumstances into consideration, when we know these have a direct impact on a patient's health outcome. Overlooking these issues will bias star ratings against Harris Health System as we care for the most complex patients, including those with sociodemographic challenges.  | George V. Masi,<br>President and CEO; Harris Health System  | <a href="mailto:Elizabeth.Greenlee@harrishealth.org">Elizabeth.Greenlee@harrishealth.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | 4. <u>Peer groups</u> . We would advocate for a peer grouping methodology. We believe that there are real differences in the complexity of care provided at an academic medical center and a small rural community hospital. <b>We would recommend that the peer groups mimic the Vizient Quality and Accountability Study cohorts: comprehensive academic medical centers, complex teaching hospitals, and community hospitals. It may also be useful to group safety-net hospitals into a single peer group. Another recommendation would be grouping based on payer mix.</b> These groupings make the implication that all hospitals within these groups would be submitting relatively the same number of measure and have a similar teaching status. | Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic                          | <a href="mailto:deylingc@ccf.org">deylingc@ccf.org</a>   | Medical University     | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Creating Peer Groupings for the Ratings: Given that the breadth and type of services can vary widely across different hospital types, we support CMS creating peer groups for the star ratings. We recommend that CMS only publicly display a hospital's peer group rating and not two ratings (an overall rating and a peer group rating). We are concerned that displaying two different ratings to patients may be confusing. Our recommended peer groups would be the following: <ul style="list-style-type: none"> <li>o AMCs/Teaching hospitals</li> <li>o Critical access hospitals</li> <li>o Rural hospitals</li> <li>o Community hospitals (Small, Medium, Large)</li> </ul>  | Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine | <a href="mailto:kachalia@jhu.edu">kachalia@jhu.edu</a>   | Health Organization    | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | CMS has also not accounted adequately for the impact of sociodemographic factors on health outcomes. Studies from government agencies and the healthcare field all suggest high relevance and the great importance of these factors, and CMS has considered using socio-demographic status to adjust readmission measures for Medicare and Medicaid dual eligibility status in the Hospital Readmission Reduction Program. While this adjustment is far from adequate, we believe it is directionally correct. CMS' Star Ratings methodology has not adopted SDS adjustments for the underlying measures.   | Marie Grause, RN, JD, President, Healthcare Association of New York State                         | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>Currently, CMS’ Star Ratings compare hospitals of different types and characteristics together. CMS is soliciting comments on hospital stratifications, which would allow hospitals to be compared to peers within similar types or characteristics.</p> <p>HANYS supports the addition of hospital stratification by peer groups to determine ratings by comparing hospitals with similar measure reporting. HANYS urges CMS to consider stratification by SDS factors (i.e., dual eligibles, area income statistics, etc.), teaching status and provider status (i.e., Critical Access Hospital vs. Prospective Payment System) <a href="#">[Figure 9]</a>.</p> <p>Stratification by these peer groups helps account for the differences in average performance levels by peer groups and limitations in specific domains due to reporting restrictions. For example, CAHs are excluded from the PSI-90 composite on which the Safety of Care domain relies, and voluntarily report HAI measures to the National Health Safety Network.</p> <p>As a result, CAHs typically have “average” scores on this domain, as the statistical modeling lacks sufficient data to estimate domain performance relative to other provider types. Additionally, these facilities have historically performed much better, on average, than other provider types on Hospital Consumer Assessment of Healthcare Providers and Systems measures.</p> <p>Additionally, stratification by SDS factors provides more meaningful benchmarks for hospitals with low-SDS patients who have unique complexities that are not included in risk-adjustment in the current readmission measures <a href="#">[Figure 10]</a>.</p> <p>However, stratification at the K-means level does not directly address peer group variation at the measure or domain level. As stated above, HANYS urges CMS to consider appropriate adjustment for SDS at the measure level, alternatives to statistical modeling or reporting at the domain/service line level rather than overall star rating to account for significant differences in reporting requirements and average performance levels between provider types.</p> | Marie Grause, RN, JD, President, Healthcare Association of New York State | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a> | Marie Grause, RN, JD, President, Healthcare Association of New York State | Please refer to the Summary Report |



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| 3/29/2019   | Peer Grouping          | HANYS does recognize the level of complexity stratification may add to the interpretation of the Star Ratings. Because the Star Ratings are too complicated to be understood and meaningfully used by both patients and healthcare providers, CMS should remove the Star Ratings as a whole  | Marie Grause, RN, JD, President, Healthcare Association of New York State          | <a href="mailto:lwillis@hanys.org">lwillis@hanys.org</a>               | Marie Grause, RN, JD, President, Healthcare Association of New York State | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | As currently implemented, CMS compares all hospitals that meet the minimum measure requirements (nine measure scores, across a minimum of group measure groups, with at least one measure group related to outcomes) regardless of differences in hospital characteristics, such as teaching or safety-net status, number of beds, or range of services provided. Academic teaching hospitals such as Tampa General Hospital perform a wide array of complicated and common procedures, pioneer new treatments, and care for broader socio-demographic patient populations that may have limited access to care. Yet under the current Star Ratings program, they are compared directly to hospitals with homogenous patient populations and to hospitals that do not perform enough procedures to be measured on a majority of the individuals included in the methodology. This had led to observations that the ratings disadvantage large teaching hospitals. According to a study published in JBJS Open Access CMS excludes some quality measures for hospitals that perform fewer than 25 surgical procedures over a three-year period. When researchers inputted estimated measures for total joint arthroplasty complications, more than a third had a different - and often lower - rating. Ratings were unchanged when incorporating the other three measures into calculations. The researchers concluded that the CMS star ratings do not fully represent the risks of undergoing procedures at low-volume hospitals, potentially misrepresent quality across facilities , and hence are of uncertain utility to consumers. | Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital | <a href="mailto:johnrothenberger@tgh.org">johnrothenberger@tgh.org</a> | Hospital  | Please refer to the Summary Report |



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| 3/29/2019   | Peer Grouping          | While the use of peer groupings is important for hospitals to have like comparisons, we believe that this concept may not be meaningful to consumers as a Star Ratings tool. In addition, we would not support the release of two separate ratings due to the potential for confusion and the likelihood that our hospitals and staff will be responsible for describing Star Ratings distinctions. Again, the Patient & Patient Advocate Work Group recommendations should be given deference related to the perceived usefulness of this methodology in Hospital Compare.   | Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health<br>Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health | <a href="mailto:cathy.simmons@unitypoint.org">cathy.simmons@unitypoint.org</a>             | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Daniel Lombardi, DO, MBA, FACOEP, VP/Chief Quality Officer, Associate Medical Director, St. Barnabas Hospital Health System  | <a href="mailto:dlombardi@sbhny.org">dlombardi@sbhny.org</a>                               | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Overall need to better risk adjust data related to academic and safety net hospitals. Peer grouping is an interesting approach to do this, but I agree would likely add more complexity to an already complex program. Can the concepts in the public comment document on pages 35 & 36 be combined with better modeling addressing patient populations (social determinants of health) and issues like transfer patterns to develop more robust risk modeling? This could provide benefits of proposed peer grouping without added reporting complexity. Please include us in further discussions of peer grouping/risk adjustment | Larry Mandelkehr, Executive Director, Hospital Quality and Innovation, UNC Health Care System  | <a href="mailto:Larry.Mandelkehr@unchealth.unc.edu">Larry.Mandelkehr@unchealth.unc.edu</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center  | <a href="mailto:ALutz@RUMCSI.org">ALutz@RUMCSI.org</a>                                     | Medical University     | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Cheryl Feeman<br>Macafee, MBA,<br>CPHQ, RHIA, Director of Quality Management   | <a href="mailto:MacafeeC@jmhn.org">MacafeeC@jmhn.org</a>                                   | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Wendy Blakemore<br>MS, BSMT (ASCP),<br>Director of Quality, Patient Safety and Utilization Management, Thompson Health | <a href="mailto:Wendy.Blakemore@thompsonhealth.org">Wendy.Blakemore@thompsonhealth.org</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligibles.   | Karen Bonilla, Senior Governmental Affairs Specialist, PAC Manager at Healthcare Association of New York State         | <a href="mailto:KBonilla@hanys.org">KBonilla@hanys.org</a>                                 | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Second, we support stratified ratings. This would allow us to be compared to our peers. Of equal importance, this information will be helpful for consumers because it would enable more valid comparisons. Our hospital treats patients who are impacted by a significant number of socio-economic factors. Given the strong impact of socio-demographic factors on patient outcomes, we recommend peer groups of a) teaching status; b) Critical Access Hospitals; and proportion of dual-eligibles. This is an opportunity for CMS to incorporate socioeconomic status into the Star ratings making this program consistent with its' HRRP, VBP, and HACRP programs. | Ronette Wiley,<br>Executive Vice President & Chief Operating Officer, Bassett Medical Center                           | <a href="mailto:jackelyn.fleury@bassett.org">jackelyn.fleury@bassett.org</a>               | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | Also, we'd argue that the individual measures may not reflect an accurate portrayal of quality care delivered at a facility due to the concerns of socioeconomic status factors. 66% of the star rating system can be adversely affected by socioeconomic status: readmission, mortality and patient experience measure groups. These groups can be controlled by factors outside of the hospitals control; for example, housing, transportation, social support, etc. CMS has adjusted payments regarding socioeconomic factors outside the control of facilities and the same must be addressed to the individual measures of the star rating system that these same factors may affect.  | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality                  | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a>             | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Additionally, another major concern, as briefly illustrated in the socioeconomic status factors, lack of peer grouping for facilities. Large medical facilities should not be grouped with small critical access facilities that do not provide similar medical care and treatments.  | Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality                  | <a href="mailto:GPike@vidanthealth.com">GPike@vidanthealth.com</a>             | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Primary objective is "to summarize information....that is useful and easy for patients and consumers to interpret."<br>What is the goal? To inform/ educate potential patients/public to a) inform their healthcare decisions or b) encourage advocacy and public pressure for organizations to improve. If it is the former, then peer groupings do not make sense. Geography usually dictates those decisions, with the need to compare/choose different types of facilities. If it is the latter, then it would make sense to be on # measures reported. % of dual eligible would be more a factor to be controlled for (adjustment) rather than a peer group. Dual eligibility would likely affect different measure groups differently so a separate peer group makes less sense here than other reporting. Peer groups by academic affiliation or services offered would likely be most beneficial to payors. I agree that two different ratings (overall and a peer group) would be confusing to public. | Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health | <a href="mailto:kathleencarrothers@gmail.com">kathleencarrothers@gmail.com</a> | Individual             | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>CAH or Average bed population of 10 or less) is beneficial for small rural hospitals to compare their data with “like” hospitals.</p> <p>We feel that 2 star ratings would be confusing to the public to interpret. This could also provide an inaccurate perception of a hospitals performance if the star rating would be significantly different between the 2 star ratings. Patient Focus Groups in Wisconsin have stated that the measures and scores are difficult to understand. We feel having 2 different scores for the same thing would add to this confusion.</p>   | Tim Size, Executive Director, Rural Wisconsin Health Cooperative                       | <a href="mailto:JLevin@rwhc.com">JLevin@rwhc.com</a>                       | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p>DHR applauds CMS ' proposal to establish peer grouping for hospitals. In this Public Input Request, CMS expressed interest and requested public comment on the establishment of peer groups for hospital ratings, and specifically which factors should be considered when establishing peer groups. DHR firmly believes that hospitals should only be compared to other hospitals that have similar characteristics; this ensures more accurate and appropriate ratings, as similar hospitals face similar challenges.</p> <p>DHR strongly recommends that CMS take into account the following characteristics when establishing peer groups:</p> <ul style="list-style-type: none"> <li>-Proportion of dual-eligible patients, similar to the grouping methodology in the Hospital Readmission Reduction Program (HRRP)2 Dual-eligible beneficiaries represent specific needs within a community and often result in a great amount of care and consideration expended by hospitals. DHR believes that considering the proportion of this specific dual- eligible population should be a factor with peer groups for Hospital Compare.</li> </ul> | Carlos J. Cardenas, MD, Chairman of the Board, Doctor’s Hospital at Renaissance Health | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital  | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>• Proportion of Uncompensated Care/ Uninsured Patients. Safety-net hospitals provide life-saving and essential access to health care to a higher proportion of low- income and uninsured populations while operating in low-margin environments with high uncompensated care costs. Additionally, the populations served by safety- net hospitals generally come into the hospital with higher acuity because they lack regular access to preventative care, disease management, or other health services. DHR believes safety-net hospitals should be</li> <li>• Hospital Level of Acuity. Hospitals should also be classified by the level of services provided as determined by the level of acuity of the hospital' s patients. Hospitals that see patients with a higher level of acuity, as measured by the hospital's case-mix index, provide a higher-level of care at a greater cost and are more likely to see complications, re-admissions, emergency room visits and other instances</li> <li>• -Number of beds: The size of a hospital, and thus its available resources, is a basic consideration when evaluating a hospital relative to others. General acute hospitals can come in all sizes from rural, small, micro, to large urban academic teaching institutions. Along with level of acuity and populations served, the size of the hospital is an important distinguishing factor to take into account when grouping hospitals by their peers.</li> <li>• -Number of measures reported: Due to the wide variability of measures on which hospitals report, it is inappropriate for all hospitals to be compared to one another regardless of the number of measures they report. For example, a small hospital with limited measure reporting should not be compared to a hospital with the resources to report on all measures available within the 7 reporting categories.</li> </ul> | Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>-Separate groups for specialty hospitals: General Acute hospitals, like DHR, should not in the same peer group as small surgical or specialty hospitals. Simply put, the level of services, the types of cases seen, the complexity of care provided, the level of acuity, and the population seen is dramatically different between a general acute community hospital and a specialty hospital that only sees a particular type of medical issue. These hospitals should not be placed in the same peer groups.</li> <li>DHR believes that these variables allow hospitals in underserved regions, such as Rio Grande Valley, to be appropriately measured and rated, while limiting the possibility of skewed scoring based on resources that a hospital may not have.</li> <li>Additionally, OHR believes that hospitals should only be given one type of star-rating: a star-rating based on peer groupings. DHR feels that assigning two star-ratings: one based on peer groupings and another based on all hospitals nationally, would be confusing to the consumer. DHR also feels that having two separate star-ratings would place less emphasis on ratings within peer-groups, which is a more accurate description of hospital performance.</li> <li>2 Department of Health and Human Services, Center s for Medicare &amp; Medicaid Services. Fiscal Year 2019 Hospital Inpatient Prospective Payment Systems Final Rule . August 2018;</li> <li><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Item/s/FY2019-IPPS-Final-Rule-Regulations.htm">https:// www.cms.gov/ Medicare/ Medicare-Fee - for -ServicePayment / AcuteInpatientPPS/ FY2019-I PPS- FinaI-Rule-Home-Page -Item s/ FY2019-IPPS-Final-Ru le - Regulation s.htm</a> 1. Accessed January 28, 2019</li> </ul> | Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health | <a href="mailto:kkincaid@appliedpolicy.com">kkincaid@appliedpolicy.com</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | Peer grouping may help to improve results if assigned based not only on hospital size but also needs to include patient complexity. CMS should explore measure performance within specific hospital peer cohorts so that hospitals with similar characteristics and risk profiles are compared to each other. LVHN supports peer grouping, if a risk adjustment methodology is incorporated and believes stratified comparisons are useful to hospital stakeholders for quality improvement activities and also to help patients and consumers best understand differences among the various types of hospitals available to them.   | Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network | <a href="mailto:Chris.Deschler@lvhn.org">Chris.Deschler@lvhn.org</a> | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Peer Compare – YES<br>We do support implementation of a peer compare that will include hospitals that “look like us” via peer grouping. We believe there is value in generating 2 stars – one overall rating based on all hospitals and a separate rating based on peer groupings. We recommend that you use the same comparative groupings as Leapfrog for consistency.   | Holly Wolfe, MBA, Director, Quality & Clinical Improvement, WellSpan Health   | <a href="mailto:hwolfe2@wellspan.org">hwolfe2@wellspan.org</a>       | Health System          | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | Kaiser Permanente generally supports exploration of peer groupings, as these are intuitively logical comparisons, and may be meaningful and useful to consumers. However, this would be exploratory work. Please see below for additional comments on the specific question of peer grouping.<br>We understand the interest in peer grouping hospitals for purposes of the Overall Hospital Quality Star Ratings – such groupings could be intuitive for consumer comparisons – but we do not believe there is an obvious method for doing so fairly or logically. Performance reporting and improvement expectations should generally be independent of arbitrary groupings that could mask performance issues. Until a reasonable set of peer groupings can be defined and tested in order to understand the likely impact of such groupings on ratings, we would not support an Overall Hospital Quality Star Ratings calculation based on peer groups only. It may be reasonable to create a separate section on Hospital Compare that contains peer-grouped ratings, but again the content and display should be carefully calibrated and tested before use by consumers. | Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals | <a href="mailto:andy.m.amster@kp.org">andy.m.amster@kp.org</a>       | Hospital Association   | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | <p><b>Cedars-Sinai strongly supports peer grouping of the overall Quality Star Ratings.</b> The use of peer groups would enhance the meaningfulness of the current ratings, given the tremendous differences in the type of services provided by various type of hospitals. <b>We support the use of teaching status as the major criterion for the peer groups with an added distinction between major teaching and minor teaching hospitals.</b> Along the same lines, a grouping of critical access hospitals will also be a useful criterion for peer groups. Cedars-Sinai does <b>not</b> support using the proportion of Dual Eligible patients as a criterion for peer grouping. That approach is most appropriate for the HRRP, because of the evidence supporting the relationship between social determinants of health, community resources, and readmission rates. Hence, consideration should be given to applying that approach (proportion of Dual Eligible patients) into the readmission measures included in the Star Rating.</p> <p>Finally, Cedars-Sinai also does <b>not</b> support using the criterion of the total number of measures reported by each hospital as a basis for peer grouping. The approach described in Question 2.d (Section 4.5.2) speaks to an important flawed assumption underlying the Overall Hospital Quality Star Rating project: the belief that as many hospitals as possible should be included, at the expense of more reliable, stable ratings. Grouping hospitals into quartiles by the number of measures reported by each hospital will not result in a meaningful peer group for hospitals that report fewer measures, because these hospitals could be reporting different measures. Single specialty hospitals also should not be included in the overall quality Star Rating system.</p> | Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center | <a href="mailto:gail.grant@cshs.org">gail.grant@cshs.org</a>                           | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | We do not support having two different Star Ratings. We feel that two different star ratings for a hospital would be confusing to consumers. We also do not feel that there should be peer grouping of hospitals as there is not a clear winner how to group them and do not feel it brings value to consumers when making a decision and looking at comparing hospitals.   | Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital                            | <a href="mailto:linnea.huinker@northmemorial.com">linnea.huinker@northmemorial.com</a> | Hospital              | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | Hospitals vary widely in the scope of services they offer and the acuity of the patients they treat. We have seen that clearly in our experience of the populations we serve. The calculation of a single star rating for all hospitals treats them as if their overall performance is directly comparable. The challenges faced by the various populations we take care of, have demonstrated to us there are vast differences in approaches and barriers to care and health. Just look at the elderly population which you would think would have similar needs but there is wide range of social and health determinants that affects their health status during their hospital course of care and the discharged course. It is recognized that patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other settings. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care. More than two-thirds of the star rating summary score is linked to outcome measures—mortality, readmission, and patient experience—all of which has been shown to be influenced by social risk factors. We urge CMS to account for differences between hospitals and factors outside hospitals’ control that influence outcomes and ratings. | Deborah Larkin-Carney, RN, BSN, MBA, Vice President of Quality & Patient Safety; RWJBarnabas Health           | <a href="mailto:Deborah.larkin-carney@rwjbh.org">Deborah.larkin-carney@rwjbh.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | We would agree with the peer grouping particularly for CAHs due to low volume metrics and the participation in MBQIP metrics and not VBP metrics, such as IPPS or OPPS measurements. For example Safety of Care NHSN measures, we submit data however our volumes are too low for credit on the star report  | Melissa Obuhanick, RN, BS, CPPS, CPHQ, Director of Quality and Risk Management; Grand River Hospital District | <a href="mailto:mobuhanick@grhd.org">mobuhanick@grhd.org</a>                         | Hospital               | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>We know that there is great variation in the demographics of the patients that different hospitals serve. Failure to effectively account for differences in socioeconomic status social needs of a hospital's respective patients, including social support and isolation, housing security, food security, and transportation, will distort comparison. A recent series of National Academy of Medicine reports have explored the need to include such factors and are exploring ways to do that for the Medicare population.</p> <p>National Quality Forum (NQF). is taking up this challenge through its Social Determinants of Health Data Integration Project. It is imperative that CMS work with NQF on this effort for not only the Star Rating initiative, but for any value-based payment or quality reporting programming for hospitals and for physicians. As it currently stands the Start Quality Ratings cover all hospitals that meet the minimum measure requirements. They do not distinguish between different types of hospitals. Many other systems, such as how Ohio distributes DSH dollars or calculates hospital payment rates, use some sort of peer grouping to account for differences. We believe it makes sense to examine whether presenting ratings among peer groups adds value and meaning for patients as they are making decisions.</p> | Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center  | <a href="mailto:Jennifer.carlson@osumc.edu">Jennifer.carlson@osumc.edu</a> | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <p>Eliminate the bias and unfair comparisons that are created among hospitals reporting (for example) 54 of 57 eligible measures, to hospitals that report much fewer measures such as 30 of 57 eligible measures.</p> <p>Allow ability to cohort like hospitals (large teaching, community, bed size), and to cohort by the number of measures reported.</p>  | David A. Milling, MD, Chairman of Quality & Patient Safety Committee, Kaleida Health; Senior Associate Dean for Student and Academic Affairs, Associate Professor, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo | <a href="mailto:dmilling@buffalo.edu">dmilling@buffalo.edu</a>             | Medical University     | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>SES is not adjusted for in the Star rating but it is in the HRRP. This adversely affects urban hospitals. The association between low SES and readmission outcomes has been long established and the HRRP program includes this adjustment yet the CMS' Overall Rating program excludes SES from the readmission domain creating inconsistency from CMS' HRRP. SES was legislated to be included when calculating readmission penalties as SES impacts outcomes. SES should be addressed in the Overall Rating model.</p> <p>Consider peer grouping as a way to stratify ratings by hospital type or characteristic. Explore measure performance within specific hospital peer cohorts so that hospitals with similar characteristics and risk profiles are compared to each other. This helps hospitals with quality improvement and helps consumers understand differences and what is available to them. There are multiple stratification approaches used by CMS in other settings -evaluate these for possible options. Peer grouping can be a temporary approach until more risk adjustment at the measure level is adopted. CMS should use its vast resources and extensive data available to the agency to determine the most appropriate peer groups. Share peer grouping methodology with hospitals in advance of publication. The stratification comparison of hospital performance should be very clear when published on Hospital Compare to help patients with interpretation.</p> | Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital                 | <a href="mailto:seamus.b.dolan@healthpartners.com">seamus.b.dolan@healthpartners.com</a> | Hospital              | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <p>ZSFG First, we believe larger hospitals, teaching hospitals, and hospitals serving a high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most vulnerable patients in need. We ask that CMS cease the publication of ratings to avoid the disproportionate effect ratings have on safety-net or teaching hospitals. ZSFG believes CMS should continue to explore creating peer groups for star ratings as a short-term strategy to address ratings biases.</p> <p>We also urge CMS to pursue further improvements to its risk adjustment approaches, as you have done previously within the Readmission Reduction Program. Direct risk adjustment approaches may obviate the need for peer grouping in the future. CMS should examine ways to account for differences among hospitals to ensure the star ratings reflect actual quality of care factors that are within the control of the hospital.</p>   | Troy Williams, RN, MSN, Chief Quality Officer; Zuckerberg San Francisco General Hospital and Trauma Center | <a href="mailto:leslie.safier@sfdph.org">leslie.safier@sfdph.org</a>                     | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>Hospitals should only be evaluated against like hospitals. We fully support using peer groups when assigning star ratings. Socioeconomic Status (SES) adjustment should be added to the methodology. It has been clearly demonstrated in the Hospital Readmission Reduction Program (HRRP) that SES is a relevant adjustment factor. Research by Chicago Healthcare Analytics also demonstrates clear differences in star ratings based on the HRRP SES Peer Group Assignments. Star Ratings should be adjusted by SES or at the very least; the Readmission Group should have this adjustment.</p> <p>4.5. Peer Grouping</p> <p>Would it be valuable to calculate Overall Hospital Quality Star Ratings among peer groups? How should the information be displayed? If CMS decides to move forward with this feature, which stakeholders do you believe would use the information and how would they use it?</p> <ul style="list-style-type: none"> <li>• We fully support presenting Star Ratings in Peer Groups. The goal of the Star Rating is to provide the consumer with actionable information about where they may want to seek care based on the quality of the hospital and care they are seeking. When patients are seeking care, they are doing so for specific conditions. All hospitals do not provide the same complexity or breadth of care, as such star ratings make more sense when assigned based on the type of care and services the hospital provides. While it may be more challenging to present the data in this manner, it will provide the patient more actionable information. Among the feasible variables that could be used for peer grouping (specialty, number of measures reported, teaching status, number of beds, critical access hospital, proportion of dual eligible patients), which would be most useful?</li> <li>• We support assigning Star Ratings in relevant peer groups. All hospitals are not providing the same type and breadth of care. Star ratings should be assigned separately for: <ul style="list-style-type: none"> <li>-Critical Access Hospitals/Hospitals under 100 beds</li> <li>-Specialty Hospitals (i.e. only provide services in very limited specialties, Orthopedics, Cancer, Obstetrics, etc.)</li> <li>-Large Academic/Teaching Hospitals providing quaternary care</li> <li>-Other Medical Surgical Hospitals</li> </ul> </li> </ul> | <p>Jeremy Boal, MD<br/>Chief Clinical Officer<br/>Executive Vice President<br/>Mount Sinai Health System</p> <p>Vicki LoPachin, MD<br/>Chief Medical Officer<br/>Senior Vice President<br/>Mount Sinai Health System</p> <p>G. Troy Tomilonus<br/>Vice President,<br/>Clinical Decision Support<br/>Mount Sinai Health System</p> | <a href="mailto:troy.tomilonus@mountsinai.org">troy.tomilonus@mountsinai.org</a> | Hospital               | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>-As a CAH there is an issue with small numbers/data sets-a large percentage for CAH's voluntarily submit data to CMS but a large number of those do not meet the minimum data set requirement for public reporting-there should be a way to explore using the CAH data that is submitted to mitigate the small data set</p> <p>-As a CAH we agree that a large number of our services are outpatient and use of outpatient measures would be beneficial but one concern is how to account for patient compliance in these types of measures</p> <p>-We support Peer Groupings (CAH's) but would like to see an Overall Star Rating comparative to all as well as the peer grouping and would suggest that comparisons be based on measures that have statistical reasonable comparisons</p> | Amy Arnett, MS, RN, CPHQ, CPPS<br>Quality/Infection Prevention Manager<br>Horizon Health   | <a href="mailto:aarnett@myhorizonhealth.org">aarnett@myhorizonhealth.org</a>                     | Hospital               | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p>Current methodology does not account for disparities in determinants of health. Peer groups: We support stratified ratings, which would allow us to be compared to our peers. This information will be helpful for consumers, because it would enable more valid comparisons. It will also be helpful for hospitals as they continue internal quality improvement efforts. Given the strong impact of socio-demographic factors on patient outcomes, we recommend these peer groups: teaching status; Critical Access Hospitals; and proportion of dual-eligible patients.</p>  | Kathleen R. Reilly, B.S., RRT, CCMSCP<br>Director, Quality and Performance Improvement<br>Finger Lakes Health (Geneva General Hospital/Soldiers and Sailors Memorial Hospital) | <a href="mailto:Kathleen.Reilly@fingerlakeshealth.org">Kathleen.Reilly@fingerlakeshealth.org</a> | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Peer groups: I support stratified ratings, which would allow us to be compared to our peers.   | Diane C. Kantaros, M.D.<br>Corporate AVP of Clinical Quality Health Quest  | <a href="mailto:dkantaros@HealthQuest.org">dkantaros@HealthQuest.org</a>                         | Individual             | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | 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.   | Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association  | <a href="mailto:nhoffman@calhospital.org">nhoffman@calhospital.org</a>                           | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>Although there is some concern that CMS star ratings disproportionately under-rate larger academic hospitals<sup>3</sup>, peer grouping would not provide any additional clarity to the consumers. The purpose of the Hospital Compare methodology is to provide consumers with a simple overall rating to help guide their decision on where to receive care<sup>4</sup>. When a consumer is reviewing Hospital Compare, we believe that they are most often looking at a specific geographical area for hospital comparison rather than looking within a peer grouping for a “large, academic hospital”, the definition of which may be meaningless or incomprehensible for many consumers. Consistent rating of hospitals, regardless of peer group, would be most simple and clear to the patient.</p> <p>3. DeLancey JO, Softcheck J, Chung JW, Barnard C, Dahlke AR, Bilimoria KY. Associations Between Hospital Characteristics, Measure Reporting, and the Centers for Medicare &amp; Medicaid Services Overall Hospital Quality Star Ratings. Jama-J Am Med Assoc. 2017;317(19):2015-2017.</p> <p>CMS. Overall Hospital Ratings Overview.</p> | John D. Poe, Chair, Quality and Affordability, Mayo Clinic                   | <a href="mailto:Schubring.Randy@mayo.edu">Schubring.Randy@mayo.edu</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p><u>3.</u> CMS should examine ways to account for differences among hospitals to ensure the star ratings reflect actual quality of care within the control of the hospital.</p> <p>Hospitals vary widely in the scope of services they offer and the acuity of the patients they treat. 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.</p> <p><u>a.</u> CMS should further examine approaches to comparing similar hospitals, while mitigating any unintended consequences, such as additional complexity for consumers.</p>   | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a>   | Health System         | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>By virtue of our safety net mission, we treat a disproportionate share of our community’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—having a substantially different patient mix and breadth of services—do not receive the same recognition. 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 an interim step on the way to true risk adjustment. Directionally, this is where the star ratings program should be headed—acknowledging and accounting for the differences in hospitals, unrelated to the quality of care they provide, that impact measure performance and ratings.</p> <p>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 unclear that the inclusion of a secondary, peer-based metric would benefit consumers. We urge CMS to examine this approach, with input from stakeholders, to identify both the variables by which peer grouping could be implemented as well as the usefulness to the patient in having this information.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a> | Health System          | Please refer to the Summary Report |



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| 3/29/2019   | Peer Grouping          | <p>In fiscal year (FY) 2019, the Hospital Readmission Reduction Program (HRRP) will implement the use of a stratified methodology to account for socioeconomic status, a provision finalized in the FY 2018 Inpatient Prospective Payment System 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.</p> <p>We are pleased that CMS has moved forward with risk adjustment in the HRRP, for payment penalty purposes, and we applaud the agency for recognizing that differences in hospitals matter when it comes to a ratings system, as well. 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.</p> | Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System  | <a href="mailto:Warren.Whitney@mihs.org">Warren.Whitney@mihs.org</a>     | Health System                                   | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p>The Joint Commission believes that all hospitals should be held to the same quality standard, therefore does not support calculating Overall Hospital Quality Star Ratings based on hospital peer groups. The Joint Commission believes there should be a single, absolute standard that all hospitals work toward rather than having separate standards for different subpopulations of hospitals.</p> <p>Comparisons by peer group should occur after the single Overall Hospital Quality Star Rating is used for each hospital. Using the overall rating, a hospital could be compared to the distribution of ratings for hospitals in its peer group for display purposes. This would give a better frame of reference to the hospital's performance than providing two potentially conflicting ratings.</p> <p>However, separate ratings for different peer groups may be confusing to the public who may not understand the distinctions between various hospital classifications. CMS should provide a description of the differences between peer groups to help patients make educated decisions.</p>  | Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission | <a href="mailto:PRoss@jointcommission.org">PRoss@jointcommission.org</a> | Healthcare Performance Improvement Organization | Please refer to the Summary Report |



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| 3/29/2019   | Peer Grouping          | Pertaining to peer grouping, KHA believes that grouping hospitals in peer groups may be one potential way to demonstrate hospital performance compared to like hospitals. However, there are so many variables that could be used for grouping, and the opportunity for greater confusion to be created for consumers, KHA agrees with the AHA's recommendation that this be considered as a potential interim step while CMS pursues further improvements to the rating methodology. KHA also encourages CMS to extend the public comment period and host virtual focus groups to gain more input and insights from hospitals regarding this approach. KHA continues to be concerned that Star Ratings do not account for social risk factor differences across hospitals.  | Karen Braman, Senior Vice President, Healthcare Strategy and Policy<br>Kansas Hospital Association | <a href="mailto:kbraman@kha-net.org">kbraman@kha-net.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | NJHA believes CMS should continue to explore 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.<br>To date, hospitals caring for sicker patients and poorer patients tend to fare worse on star ratings. Specifically, teaching hospitals, hospitals that report on larger numbers of star ratings measures, and hospitals receiving the highest disproportionate share hospital (DSH) payments (a proxy for the extent to hospitals serve the poor) all have ratings that are, on average, lower than other hospitals.<br>The basic notion of peer grouping is that it is fairer to compare hospitals that are similar to one another than it is to compare hospitals with very different characteristics. Furthermore, peer grouping is a viable approach to leveling the playing field in comparing hospital performance.<br>Indeed, CMS already uses a peer grouping approach in its Hospital Readmissions Reduction Program (HRRP) by placing hospitals into peer groups based on the proportion of dual-eligible patients they treat. This has resulted in some lowering of penalties for those caring for the poorest communities. | Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association                 | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a>       | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | We urge CMS to explore peer group stratification approaches as an interim step to improving the fairness of star ratings. The most promising variables to use in peer grouping should include those found to have an association to star ratings that are generally outside the control of hospitals. These include the number of reported measures and the proportion of dual-eligible patients. CMS could consider peer groupings using only one of those two variables, or a peer grouping based on a composite of those two variables.  | Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association  | <a href="mailto:JChebra@NJHA.com">JChebra@NJHA.com</a>             | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <u>Accounts for potential biases</u> . The ratings must account adequately for differences in the clinical and social risk factors across the patients and communities that hospitals serve. Hospitals that serve sicker and poorer patients, patients with social comorbidities such as addiction and homelessness, or patients with limited health or English-language literacy should be on a level playing field with all other hospitals. The AHA has noted repeatedly that the current approach to ratings disadvantages hospitals caring for poorer communities, as well as those like academic medical centers that tend to care for higher complexity patients and critically ill patients transferred from other sites. | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association   | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>Peer grouping. Though peer grouping would be an improvement over the current non-grouping methodology, MHA believes CMS should immediately 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.</p> <p>To date, hospitals caring for sicker patients and poorer patients or those with a high burden of social comorbidities tend to fare worse on star ratings. Specifically, teaching hospitals, hospitals that report on larger numbers of star ratings measures, and hospitals receiving the highest disproportionate share hospital (DSH) payments (a proxy for extent of hospitals serving the poor) all have ratings that are, on average, lower than other hospitals. According to Medicare’s own data, 70% of hospitals nationwide are slated to receive Medicare DSH payments in 2019 compared to 75% of those in Massachusetts. This is a great concern where many of our hospitals deliver high-quality care to significant portions of disadvantaged patients, but where this high quality of care is not always reflected in their ratings. Peer grouping approaches attempt to create groupings of hospitals that are similar to one another on specific characteristics, comparing the performance of hospitals within those groupings. The basic notion is that it is fairer to compare hospitals that are similar to one another than it is to compare hospitals with very different characteristics. The most promising variables to use in peer grouping should include those found to have an association to star ratings that are generally outside of the control of hospitals. These include the number of reported measures and the proportion of dual-eligible patients. CMS could consider peer groupings using only one of those two variables or a peer grouping based on a composite of those two variables. Separately from grouping to account for sociodemographic and/or comorbid factors, CMS should explore separate ratings for specialty and non-specialty hospitals, as specialty hospitals tend to garner more stars, but they also have fewer variables driving the models.</p> | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | There are some inherent shortcomings with peer grouping approaches, as observed with CMS’s implementation of dual- eligible peer grouping in the HRRP. The use of peer groupings involves somewhat subjective choices about where to set the cut points of a particular group. For example, those hospitals at the upper end of one group and those at the lower end of the next group would have similar proportions of dual-eligible patients but would be placed into different groups for performance comparison purposes. Furthermore, direct risk adjustment would help improve the precision of performance comparisons by ensuring that measure scores reflect the issues most relevant to each measured outcome. For example, in peer grouping, one has to assume that dual-eligible status is as large a determinant of performance for readmissions as it is for hip and knee complications when, in fact, the effect of dual-eligible status may be slightly different for each measure. Therefore, although peer grouping may result in some improvements as a temporary “Band-Aid”, we strongly urge CMS to bypass peer grouping and move directly to adequate risk adjustment of the measures in star ratings to eliminate concerns with cut-off points and which variable(s) to use for groupings.   | Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association | <a href="mailto:KStevenson@mhalink.org">KStevenson@mhalink.org</a>             | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | CMS solicits input regarding the value of calculating the Overall Hospital Quality Star Rating based on peer groups of hospitals and whether there should be multiple star ratings generated (e.g., one overall rating based on all hospitals and a separate rating based on peer groupings) or just a single star rating based on peer grouping. Generally, we support the current reporting of a single star rating for a hospital. Exploring the impact of an additional (i.e., peer grouped) rating would require: (1) sufficient agreement on the most important factors to consider in the grouping algorithm; (2) that differences between the different star approaches can be easily explained to consumers; and (3) that, assuming the two rating systems ultimately produce materially different results, the health systems clearly understand which rating system CMS most values or intends to incent, as well as the driving factors. Absent ensuring these ends are achieved, adding an additional – and perhaps discrepant – set of results will likely add confusion for both patients and providers. We also echo AHA’s comments that CMS should 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. | Peter M. Leibold, Chief Advocacy Officer, Ascension   | <a href="mailto:Danielle.White@ascension.org">Danielle.White@ascension.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>4.5 Peer Grouping:<br/> We do not support, it is difficult to identify the variable that would guide the peer grouping. Use of dual eligible in readmission has been of limited benefit. Improved case mix risk adjustment and socio-economic status data mitigates the need for peer grouping. This may occur organically if hospitals are strongly encouraged to report ICD-10 Z-codes, especially Z55 - Z65.</p>  | Dale N. Schumacher, MD, MPH, President, Rockburn Institute              | <a href="mailto:dale.schumacher@rockburn.org">dale.schumacher@rockburn.org</a>     | Healthcare Performance Improvement Organization | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | <p><u>2.</u> CMS should examine ways to account for differences among hospitals to ensure the star ratings reflect actual quality of care within the control of the hospital.<br/> Hospitals vary widely in the scope of services they offer and the acuity of the patients they treat. 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.</p> <p><u>a.</u> CMS should risk adjust measures in the methodology to account for the socioeconomic and sociodemographic factors that complicate care for vulnerable patients.</p> <p>Essential hospitals go above and beyond medical treatment to care for disadvantaged patients every day. 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.</p> | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association                            | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>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.<sup>3</sup> 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.<sup>4</sup> 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.</p> <p>While America’s Essential Hospitals supports the inclusion of measures that cover multiple dimensions of quality, certain measures in the methodology—including those in the readmission group—are biased against essential hospitals for reasons beyond the control of the hospital. Risk adjusting measures for these factors will ensure that 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.</p> | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>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 implemented risk adjustment for a subset of star ratings measures that is meant to adjust for plans serving this vulnerable population. 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 derive ways to incorporate risk adjustment across programs, including hospital star ratings, and capture accurate hospital quality performance.</p> <p><u>a.</u> CMS should further examine approaches to comparing similar hospitals, while mitigating any unintended consequences, such as additional complexity for consumers.</p> <p>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—having a substantially different patient mix and breadth of services—do not receive the same recognition. 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 an interim step on the way to true risk adjustment. Directionally, this is where the star ratings program should be headed—acknowledging and accounting for the differences in hospitals, unrelated to the quality of care they provide, that impact measure performance and ratings.</p> | Bruce Siegel, MD, MPH, President and CEO, America’s Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>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 unclear that the inclusion of a secondary, peer-based metric would benefit consumers. We urge CMS to examine this approach, with input from stakeholders, to identify both the variables by which peer grouping could be implemented as well as the usefulness to the patient in having this information</p> <p>4 See, e.g., National Quality Forum Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. <a href="http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx">http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx</a>. Accessed March 14, 2019.</p> <p>America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. <a href="http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/">http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/</a>. Accessed March 14, 2019.</p> | Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals | <a href="mailto:mguinan@essentialhospitals.org">mguinan@essentialhospitals.org</a> | Hospital Association  | Please refer to the Summary Report |



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| 3/29/2019   | Peer Grouping          | <p>Star ratings fail to account for social risk factor differences across hospitals, or to provide valid peer groupings for like to like hospital comparisons.</p> <p>There is significant peer-reviewed literature showing that hospital performance on the outcomes included in Star ratings can be affected by factors outside the control of the hospital (e.g., housing, food insecurity, social support, and transportation). Without adjustment, star ratings will put hospitals caring for poor communities at an unfair disadvantage, and mislead the consumer. Appropriate measure by measure socioeconomic risk adjustments are needed, to allow for closer like to like comparison. Two-thirds of a hospital's star rating is based on its readmissions, mortality and patient experience performance. CMS already has implemented a congressionally-mandated social risk factor adjustment in the hospital readmissions penalty program. And CMS has used its discretion to account for the impact of social risk factors in some of its other measurement programs such as Medicare Advantage star ratings, and the Merit- based Incentive Payment System (MIPS). Yet, hospital star ratings inexplicably continue to lack any adjustment for social risk factors.</p> <p>VCU Health System supports peer grouping and welcomes this as soon as possible. Hospital peer groups create more meaningful actionable hospital comparisons. Suggestions for groupings include: academic and community focusing on the volume of services and patient conditions cared for. VCU Health System supports each hospitals having a singular star rating based on peer grouping.</p> <p>As addressed in our previous comment on Star Ratings, VCU Health System and the American Hospitals Association found the following eight characteristics to be significant in identifying two distinct hospital cohorts:</p> <ul style="list-style-type: none"> <li>• Total Outpatient Visits</li> <li>• Acute Transfers In volume</li> <li>• Case Mix Index</li> <li>• Inpatient Surgical Cases as a percentage of all admissions</li> <li>• Outpatient Surgical Cases as a percentage of total surgical cases</li> </ul> | Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckely, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality & Safety First Programs; VCU Health System | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <ul style="list-style-type: none"> <li>Trauma Service</li> <li>Bone Marrow Transplant Service</li> <li>Solid Organ Transplant Service</li> </ul> <p>We recommend CMS cohort stratification using similar features, which will add credibility and validity to the hospital rankings.</p>   | Ralph R. Clark III, M.D., Chief Medical Officer and Vice President for Clinical Activities; Peter F. Buckely, MD, Dean, VCU School of Medicine, Executive VP for Medical Affairs; Thomas R. Yackel, MP, MPH, MS, President, MCV Physicians; Shane Cerone, Interim Chief Executive Officer; Robin Hemphill, MD, MPH, Chief Quality and Safety Officer; L. Dale Harvey, MS, RN, Patient Safety Fellow Director, Performance Improvement, Quality & Safety First Programs; VCU Health System | <a href="mailto:eryn.leja@vcuhealth.org">eryn.leja@vcuhealth.org</a> | Health System         | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | We agree with the proposal to rate hospitals within peer groups due to extensive differences in the services they provide, their sizes, the patient populations they treat, and their reported numbers of measures. Of the feasible grouping factors listed, our preference would be by bed size. If CMS were to implement peer grouping, great caution would be required in developing a simplistic approach, as the Star Ratings are intended to be an understandable consumer tool to assist with healthcare decision making. | Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center   | <a href="mailto:Panzarellolm@upmc.edu">Panzarellolm@upmc.edu</a>     | Hospital              | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | 2. Develop peer groupings/cohorts based on teaching status (AMC versus Community Hospital), facility size, and/or socioeconomic status (as done in HRRP). If separate cohorts are not desired or feasible for facility size or socioeconomic status, risk-adjusting for these variables should be considered. To avoid confusion and possible redundancies, we recommend that Hospital Compare only displays Stars based on a hospital's defined cohort or peer grouping, with these designations clearly stated and defined on the Hospital Compare website. It is our belief that creating such cohorts/peer groupings should help reduce these biases which are outside the control of the hospital.   | Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health<br><br>Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health | <a href="mailto:Tony.Calabria@Medstar.net">Tony.Calabria@Medstar.net</a>   | Health System          | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Our users also remarked that CMS needs to be careful about straying from the original purpose and charter of Hospital Compare. We think that this level of complexity is unnecessary, will further confuse users, and will incentivize hospitals to play “the peer group game”.<br>Our users thought peer grouping would be confusing to consumers. Hospital staff and the patients from the Patient Family Advisory Council expressed strong reservation about changing the Overall Hospital Quality Star Rating system in this manner. Only hospital executives expressed interest in this. Our users could not agree on a small set of grouping characteristics to use if this were to move forward. One user suggested that you should get a star rating by domain for facilities you may get a helicopter vs. ambulance ride too. Another user suggested that they wanted to know both how we compare to other small facilities and how we compare nationally. Another user suggested that peer groups should be regional (i.e., within 100 miles of zip code xxxxx, this hospital performs this well in comparison. Another user suggested that it should be organized by population of the community similar to the way we define small, medium, and large facilities for the purpose of ER volumes and metrics. The majority of our Patient Family Advisory Council did not believe that an average patient would travel unless they specifically set up a “surgical vacation”. | Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System  | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a> | Health System          | Please refer to the Summary Report |

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| 3/29/2019   | Peer Grouping          | <p>Hospital staff familiar with Press Ganey and general methods of subgroup statistics are concerned with “the peer group game” hospitals will inevitably play. Specifically, adding a star rating specific to some type of subgroup (academic, critical access, rural, small, etc.) encourages facilities to be the best in a narrow group. This inherently is in opposition to what the Overall Hospital Quality Star Rating is all about, namely, driving nation-wide improvement in healthcare operations. We believe that great care should be consistent regardless of the type of, size of or distribution of services for a given hospital.</p> <p>Additionally, our users consistently identified that demographic profiles would become yet another challenge. While profiles of facilities are relatively consistent, making sure updates to profiles were not “just because” would be yet another layer of complexity to this process.</p> <p>Instead of instituting peer grouping, multiple users suggested that CMS should just lower the volume thresholds for public reporting of a measure across the board. The majority of our users supported the idea that this is a “convenience vs. quality” debate. Since there is no reason you shouldn’t have both, we ultimately thought the conversation of peer groups is masking an undetermined problem.</p> | Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System                             | <a href="mailto:joshua.fetbrandt@gmail.com">joshua.fetbrandt@gmail.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <ul style="list-style-type: none"> <li>• It is extremely important to group hospitals in some fashion. It is negligent to group all hospitals together using the same rating formula and expect fair outcomes. A large percentage of hospitals that scored 5 stars were smaller hospitals. Community hospitals that take all patients and see a wide range of service lines are at a severe disadvantage when compared to other hospitals.</li> <li>• A hospital’s size, location, specialties and teaching designation all influence the types of patients a hospital cares for. Grouping hospitals by one or more of these factors would provide a more meaningful framework for consumers and be fairer to the hospital providers. We believe multiple star ratings for a single hospital would be confusing.</li> </ul>   | Jean Cherry, FACHE, Executive Vice President, Med Center Health                           | <a href="mailto:jean.cherry@mchealth.net">jean.cherry@mchealth.net</a>     | Healthcare System      | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <ul style="list-style-type: none"> <li>• Support the concept and favor in AAMC peer group</li> </ul>  | Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center | <a href="mailto:deede.wang@vumc.org">deede.wang@vumc.org</a>               | Medical University     | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>As currently designed, the Star Rating Program does not provide an accurate picture of CAH hospital quality for the following reasons:</p> <p>A. The Star Rating Program methodology is built to compare acute care hospitals that have high patient volume and are required to participate in mm1erous quality reporting programs;</p> <p>B. Many CAHs do not produce sufficient data for CMS to assign a star rating under its existing methodology, resulting in large information gaps as to this provider type and competitive harm to CAHs that do generate sufficient data;</p> <p>C. Ratings for CAHs that do receive a star rating from CMS are likely to be based on extremely limited data sets because CAH quality reporting requirements do not align with Star Rating Program-selected measures, and there is a wide range in service offerings and availability among CAHs across the country; and</p> <p>D. Low patient volumes, combined with a low number of measures available for CAHs, lead to wide, and potentially arbitrary, variances in CAH star ratings between update cycles. A small change in any one measure can easily result in a significant change to a CAH ‘s star rating.</p> <p>As discussed above, Carthage acknowledges and agrees with CMS’ concern that patients should have access to accurate, reliable data in order to make informed decisions regarding their health care. This is particularly true in the rural communities served by Carthage and other CAHs, where patient treatment decisions may result in patients traveling many miles to seek health care services. Each of these issues is discussed in greater detail below.</p> <p>There is a wide range of services offered by CAHs, based on geographic specialist availability, resources, and other factors. And CAHs are subject to geographic and other limitations that have an outsized impact on CAH quality and performance measures. By way of example, patients who are transported to Carthage often have to travel great distances to receive care, and patients who Carthage transfers out are subject to similar obstacles. Extended travel times increase the difficulty of providing patient care.</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>In upstate New York, it is not uncommon for severe weather to compound these issues, including circumstances where ambulances will refuse to pick up patients and the weather is too severe for helicopters to fly. Given the inherent design and structure of the Star Rating Program, CAHs and other small, rural hospitals are placed at an immediate competitive disadvantage. CMS should act to mitigate the potential harm that CAHs face as a result of this disadvantage, as described in more detail below.</p> <p>As noted above, CAHs are not required to participate in the quality reporting programs that underpin the Star Rating Program. Where CAHs do participate in these programs, the participation is generally limited to specific measures required through other laws (e.g., submission of HCAHPS scores through QualityNet). Moreover, because CAHs do not have high patient volume, it is likely that there will be insufficient data for CMS to generate statistically reliable scores for these facilities for the quality measures that are reported.</p> <p>For example, the Star Rating Program "Safety of Care" domain, as currently constructed, includes a number of infection-related quality measures (e.g. CAUTI/CLABSI infection rates). While acute care hospitals are required to report this data to CMS through NHSN by virtue of their participation in other quality reporting programs, CAHs are not. MBQIP, currently the most robust reporting program for CAHs, lists these measures as optional, or aspirational, for CAHs to track and submit. As a result of these inconsistencies, the Star Rating Program evaluates few data points that readily evaluate CAH quality reporting efforts. Given these gaps in information, CMS should take steps to ensure that star ratings for CAHs can be based on quality information that CAHs actually track and report.</p> <p><b>Recommendations</b></p> <p>C. Develop an Alternative Methodology for CAHs. CMS could also develop a separate star rating methodology for CAHs. This new methodology would be aligned with current CAH quality reporting requirements (e.g., MBQIP measures), and be designed to encourage CAH participation in that program with the facilities' limits and capabilities. Creation of an alternative methodology would also assist CMS by allowing for increased precision in measure selection and grouping, though CMS should carefully design the methodology to account for the disparity in services offered by different CAHs.</p> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>Carthage would discourage CMS from implementing a system involving two star ratings (one compared to all hospitals, one only to CAHs), as Carthage believes this would be confusing for consumers, and would not address the more substantive methodological problems at issue.</p> <p>D. Adopt a Peer Group Methodology. If CMS elects to continue evaluating CAHs under its existing star rating methodology, CMS should develop a peer group methodology as proposed in its request for public input. CAHs are fundamentally different than large acute care facilities, teaching hospitals, and other provider types. CAHs serve rural, remote populations where access to care is an ongoing concern, have limited resources and treatment scope, and are subject to different quality tracking and reporting requirements. These facilities should be considered together, rather than as part of a large group that includes different facility types, and CMS should take steps to differentiate these provider types in its public-facing information. Several alternatives to achieve this differentiation are discussed below:</p> <ol style="list-style-type: none"> <li>1. Create a Separate CAH Quality Landing/Search Page. CMS could (and should) take steps to differentiate small, rural providers like CAI-Is from large acute care facilities. One potential option would be to create a separate landing and search page for CAHs, where additional information regarding these facilities can be included in order to provide consumers with additional context and information.</li> <li>2. Provide Additional Consumer Information Regarding Facility Types. CMS should also take steps to provide additional information to consumers regarding the various facility types to which it assigns star ratings. Additional information regarding facility size, population, resources, and other requirements will provide additional, helpful context for consumers and help consumers make informed decisions.</li> <li>3. Develop Visual Indicators for Different Provider Types. Where CAH, large hospital, and other provider types are presented side-by-side, CMS should consider developing visual indicators (e.g., color highlighting, symbols, etc.) to allow for quick differentiation between provider types on the Hospital Compare website. Ideally, these visual indicators will track back to the additional consumer information outlined above to provide a seamless informational experience for consumers interested in hospital quality information.</li> </ol> | Rob Bloom, CFO;<br>Carthage Area Hospital        | <a href="mailto:rbloom@cahny.org">rbloom@cahny.org</a> | Critical Access Hospital | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | <p><b>Lack of Hospital Stratification Limits Usefulness of Star Ratings &amp; Creates Hospital Bias</b></p> <p>Vizient encourages CMS to adopt a hospital stratification approach. CMS introduced hospital groupings based on the percentage of dual-eligible patients, which evaluates hospital readmission performance relative to hospitals with similar patient challenges (Quintile-1 represents the lowest percent of dual-eligible, Quintile-5 represents the highest). When socio-demographic status (SDS) is not incorporated into the scoring methodology, hospitals with a higher proportion of complex patients have lower hospital Star Ratings. All of our members believe and practice that every patient who seeks care should receive the same high-quality care. We encourage CMS to monitor this issue for potential unintended consequences, and continue to look for ways to adjust for the risk that some hospitals face due to the proportion of vulnerable patients that they serve. As shown below in <a href="#">[Table 16]</a>, hospitals with the highest percent of dual-eligible (Quintile-5) patients earn 1-star in the CMS Star Rating program indicating that the current CMS Star Rating program lacks appropriate adjustment for not only patient socio-demographic challenges, but also is limited in the current methodology’s ability to account for patient clinical severity or complexities.</p> <p>This is especially notable in Academic Medical Centers (AMCs) – with a high proportion represented in the Quintile 4 and 5 percent dual-eligible categories, as compared to Community Hospitals (COMM) and Complex Teaching Medical Centers (CTMC), as shown in <a href="#">[Table 17]</a>, representing the percentage of hospitals in each cohort that fall into the CMS quintiles used in the HRRP.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | <p>As a result, academic medical centers have a higher proportion of 1 and 2 star hospitals in the February 2019 Star Rating distribution chart <a href="#">[Figure 11]</a>, compared to their community hospital counterparts – indicating an unintentional bias against hospitals with more complex patient populations. Vizient reiterates that safety-net hospitals have other unmeasured differences in patient characteristics that may contribute to differences in readmission rates<sup>6</sup>. SDS factors in risk adjustment allows for fair cross-provider comparisons and does not penalize one provider over another – or give the impression that one provider provides lower-quality care simply due to their ability and readiness to treat any patient. We urge CMS to utilize methodology that encourages equitable care delivery, while also accounting for the disproportionate penalties for safety-net providers and academic medical centers.</p> <p>Vizient identified additional methodological imbalances that resulted by including specialty hospitals in the Overall Hospital Star Ratings. Approximately 44 specialty hospitals were listed, including orthopedic, heart and vascular, and a rehabilitation hospital. Despite their small representation in the overall Hospital Compare data, 30 of the 44 (68 percent) received a 5-Star Rating. While it is certainly important to evaluate performance for these hospitals, combining such a heterogeneous mix of hospitals limits the Star Rating’s meaningfulness and value for patients.</p> <p>As Vizient shared in our September 2017 comment letter to CMS, until the appropriate hospital cohorts are defined within the CMS Star Rating methodology, hospitals with more complex, tertiary or quaternary care will be unfairly labeled as providing sub-par care. Vizient strongly urges CMS to ensure that safety-net and outlier hospitals are not disproportionately impacted – and recognize that these hospitals treat the most vulnerable and complex patients. Additionally, Vizient detailed the Quality and Accountability framework it utilizes for setting hospital cohort criteria to create meaningful and actionable benchmarks and comparisons for its hospital members. This criteria includes relevant volume thresholds that differentiate patient comorbidities and surgical complexity – including the number of solid organ transplants, cardiac surgery and neurosurgery cases, acute transfers in from other hospitals and trauma service line volume.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>Leveraging this criteria, we created a third hospital ranking group to accompany our current Comprehensive Academic Medical Center and Community Hospital groupings. This third cohort, the Complex Care Medical Center group, represents large, complex organizations that focus on special patient services or care, such as safety-net or specific surgical populations. The criteria used to define these cohorts was identified using a combination of exploratory data analysis (measure correlations) of hundreds of data elements and further refined using robust clustering analysis and subject matter expertise to arrive at four main volume driven criteria – solid organ transplants, acute transfers-in, trauma cases, cardiothoracic and neurosurgery volumes. This cascading criteria further supports more meaningful comparisons for hospitals taking care of unique patient needs. Additionally, Vizient developed a separate ranking framework and measures to support critical access hospitals (CAHs), oncology-specific medical centers and pediatric hospitals, which will be introduced in 2020. By splitting hospitals into relevant cohorts, Vizient’s modeling more accurately reflects a specific hospital’s performance and corresponding rating.</p> <p>Vizient tested an alternative methodology on the February 2019 Star Ratings data utilizing both clear, standardized weights and appropriate hospital groupings. The standardized weights provide transparency into the rating process and offer a replicable formula hospitals can follow as they work towards tangible improvement. To account for missing or low-volume denominators, Vizient re-allocated the weight from that measure equally to the other measures within that domain. This ensures a fair and balanced score can be achieved for all hospitals. Additionally, hospitals grouped into cohorts based on the complexity of the patients treated is a key recommendation in order to provide more actionable and reliable hospital comparisons. The three groups used by Vizient were Comprehensive Academic Medical Centers, Complex Teaching Medical Centers, and Community Hospitals referenced above. Critical Access Hospitals and hospitals solely focused on specialty care, such as orthopedics or cardiovascular care, provide a different level of care from the other hospitals in this analysis and were therefore removed.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>Vizient recommends the development of another group or groups specifically tailored to these unique hospitals. Under the existing Star Rating methodology, hospitals providing more complex, tertiary or quaternary care are artificially labeled as providing below average care, as shown in Graph 1. Splitting the hospitals into relevant groups also provides a weighting adjustment by only comparing hospitals to a population of their peers. By separating hospitals into homogenous cohorts, Vizient is able to offer a more accurate look at a specific hospital's performance and recommends CMS consider a similar approach. Given the methodological limitations and imbalanced evaluation of various hospital types within the same scoring framework, Vizient fully supports hospital or peer groupings and has outlined our recommendations above regarding a robust process for identifying differentiating hospital characteristics based on patient acuity and complexities – as well as the depth and breadth of services offered.</p> <p>Vizient suggests a simplistic approach to displaying hospital star ratings. While CMS could certainly explore displaying a 'Top Hospital' within each hospital peer group, this effort may be unnecessary as long as the public is aware the hospital is recognized as a 'Top Hospital'. Additional acknowledgements or creation of a second 'Overall' star rating would be unnecessary. CMS has experienced success with hospital grouping using the percentage of dual-eligible patients in the HRRP, and Vizient encourages CMS to explore similar approaches for the Star Ratings. As shown in our CMS Hospital Grouping assessment, hospitals grouped with like-hospitals (i.e., their peers that offer similar services and care for similar patients) are evaluated in a more consistent, robust and comparable way that provides clearer insight into performance for both providers and the public.</p> <p>While we appreciate CMS' possible peer grouping scenarios, we strongly believe that hospital peer grouping should be based on relevant volume thresholds that differentiate patient comorbidities and surgical complexity: the number of solid organ transplants, cardiac surgery and neurosurgery cases, acute transfers in from other hospitals and trauma service line volume.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>In arriving at these criteria, Vizient explored many of the options provided and found that no one single factor or characteristic provides sufficient separations or adjustments for hospitals differences. The proportion of dual-eligible patients, while insightful and relevant for readmissions and excess days measures, does not fully represent the severity or complexity of patients as would transfer in status or trauma case volume. Similarly, for teaching status or number of beds, these characteristics provide some insight, but given the variety of teaching programs and the different severity of the types of patients, Vizient found these criteria, used in isolation, were limited in creating ‘like-hospitals’.</p> <p>CMS’ recommendation to evaluate measures reported is a step forward toward evaluating the types and volume of patients seen by the hospitals, but would not necessarily adjust the differences across measures reported. For instance, if hospital A reports three heart failure measures and hospital B reports three surgical complication measures, the comparison in outcomes may not be as relevant.</p> | Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc. | <a href="mailto:Chelsea.arnone@vizientinc.com">Chelsea.arnone@vizientinc.com</a> | Healthcare performance improvement company      | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <p>It is important to understand the numerous and variable risks associated with socio-demographic factors that are outside of the control of the provider that can effect outcomes. Any star rating should account for social risk factors in the methodology. As a first step, Premier supports peer grouping; however, we urge the agency to consider approaches to account for a broader set of social risk factors. Should CMS move forward with the incorporation of peer groups, the agency must also consider how to display such information to the public. Inclusion of a secondary peer-based five-star metric could add confusion to a program that is already difficult to interpret for the average consumer of this data. As such, the agency should continue to seek stakeholder feedback to evaluate how peer grouping could be implemented as well as the usefulness to the patient in having this information.</p>  | Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance      | <a href="mailto:aisha_pittman@premierinc.com">aisha_pittman@premierinc.com</a>   | Healthcare Performance Improvement Organization | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>MGH would like to endorse the study of peer groupings, such as teaching status, in the CMS Overall Hospital Quality Star Rating. Hospitals can differ greatly by case types and complexity and when hospitals are not appropriately stratified, it could create unfair, and potentially misrepresented, performance comparisons. We recommend that peer groupings be developed and shared so that hospitals can provide input on the results and the format for reporting to the public. At this point, our preference would be to show results as overall star ratings (all hospital types) and stratified by peer group. This provides the maximal amount of information for patients who may sometimes be choosing just among academic centers, and in other instances between an academic center and a community hospital.</p> <p>If CMS decides to use peer grouping, MGH would not suggest using dual eligible status to define peer groups. The criteria for Medicaid eligibility differ by state, and thus dual eligible status has not been proven to be a reliable socioeconomic status indicator. It is also not clear that socioeconomic status is a reasonable way to adjust or stratify providers, as some performance indicators are related while others may not be, such as hospital acquired infection rates and risk-adjusted procedural mortality rates.</p> | Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital | <a href="mailto:emort@partners.org">emort@partners.org</a> | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | <p>CMS currently publishes ratings across all hospitals regardless of hospital characteristics such as range of services provided or populations served leading to concern that this does not constitute an apples-to-apples comparison. CMS seeks feedback on peer grouping in order to allow comparisons across hospitals that share key attributes understood to influence the rating. The FAH supports peer grouping across dual eligibility status as a first step towards improved risk adjustment. However, risk adjustment itself is necessary and CMS should continue to work toward implementing that. A fully defined socioeconomic status risk adjustment method is preferred.</p> <p>Although FAH supports peer grouping to allow comparisons across hospitals with shared characteristics, FAH is concerned that expanding the use of peer grouping to include multiple levels of stratification in addition to proportion of population with dual eligibility would likely complicate interpretation of the Star Ratings for consumers. FAH urges CMS to test any potential stratified comparisons of star ratings among hospitals, physicians, patients, families, and caregivers and seek their feedback prior to any implementation.</p>  | Chip Kahn, President, CEO, Federation of American Hospitals   | <a href="mailto:csalzberg@fah.org">csalzberg@fah.org</a>   | Hospital Association   | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | The ratings must take into account the variation in the communities the hospital serve, the social risk factors in the communities and an understanding that poorer communities and academic medical centers often have a higher complexity patient base. We would ask CMS to better risk adjust the rating system to account for the variation of patient bases across the hospitals in the United States.   | Michael D. Richards, System Vice President, Government Affairs and Public Policy; SSM Health  | <a href="mailto:Michael.richards@ssmhealth.com">Michael.richards@ssmhealth.com</a> | Health System          | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | Christiana Care supports calculating the Overall Hospital Quality Star Ratings based on peer grouping of hospitals. With diverse hospitals and communities throughout the country, peer grouping holds promise as comparisons with ‘like-me’ hospitals provide a more accurate assessment of hospital performance and opportunity. The most useful variables to use for peer grouping include: Case Mix Index, Trauma Service, Acute Transfers In, Socioeconomic Status, and Total Discharges.  | Delilah Greer, MPH, Director of Data Informatics and Analytics; Christiana Care Health System | <a href="mailto:dgreer@christianacare.org">dgreer@christianacare.org</a>           | Healthcare System      | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | We support calculating the Overall Hospital Quality Start Rating results based on peer grouping so that hospitals would be compared to those that “look like them.” Measure groups could be distinguished using characteristics such as teaching hospitals, total outpatient visits, acute transfers in, case mix index, number of beds, inpatient surgical cases as a percentage of all admissions, outpatient surgical cases as a percentage of total surgical cases, trauma service, bone marrow transplant service or solid organ transplant services. Our experience suggests case mix index and number of beds achieves the goal and is simple for patients to understand. Comparisons between hospitals with similar characteristics would be more useful to patients and allow them to more easily assess the differences between facilities. To make it most user-friendly, we strongly recommend that only one star rating be generated based on peer grouping rather than two star ratings, with one based on all hospitals and a second based on peer grouping. | George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health                       | <a href="mailto:George.t.blike@hitchock.org">George.t.blike@hitchock.org</a>       | Healthcare System      | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p>AHPA supports using peer groups to calculate the Overall Hospital Quality Star Ratings as well as risk-adjusting for patient populations and complexity of cases. We believe that this approach, currently used in the HRRP, would more fairly compare performance among hospitals and lead to more accurate star ratings. Under the current methodology, hospitals with more data and reported domains tend to perform worse than hospitals with fewer measures and domains reported. Hospitals that report fewer measures (smaller, non-teaching, specialty hospitals) tend to have more stars. 2 These hospitals tend to be significantly different than their counterparts and a star rating system should account for these differences. Therefore, we recommend that CMS stratify the ratings based on both the characteristics and the types of hospitals. CMS should provide risk-adjustment for patient population and complexity of cases and use these components to cluster hospitals into different peer groups. AHPA urges CMS to risk-adjust measures for dual-eligible status. This risk-adjustment is currently being done in the Hospital Readmission Reduction Program (HRRP) and we believe it should be replicated across all Medicare quality programs. Alternatively, a hospital's patient population and the complexity of cases need to be factored into the structural equation models to calculate the proper loading scores for each hospital.</p> <p>After adjusting for peer group characteristics, AHPA recommends using a single rating for all hospitals (an overall star rating) and a secondary rating based on peer grouping. We believe that this rating methodology would allow consumers to compare hospitals more accurately. For example, a patient interested in oncology services would be able to compare the quality of a cancer hospital with other cancer hospitals. While AHPA does not recommend that the number of beds be used to establish hospital peer grouping, below are the variables that we do believe should be included:</p> <ul style="list-style-type: none"> <li>• Dual-eligible status,</li> <li>• Type of hospital: teaching/non-teaching/boutique or specialty hospitals,</li> <li>• Number of measures reported,</li> <li>• Critical access or non-critical access hospital.</li> </ul> | Carlyle Walton, FACHE, President; Adventist Health Policy Association | <a href="mailto:Carlyle.walton@adventhealth.com">Carlyle.walton@adventhealth.com</a> | Healthcare System     | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | We believe the proposals outlined by CMS would further confuse patients. Consumers do not search according many of the hospital categorizations mentioned (for example: # of beds, teaching versus non-teaching, or number of measures used in the ratings). Consumers would likely struggle to understand these concepts. Specialty hospitals and rural hospitals are perhaps the only two groups of hospitals that hint (albeit indirectly) at what patients actually search for: a hospital that can address their particular condition or needed procedure, within a certain distance to their home, which accepts their insurance, and has the highest quality possible. Patients are agnostic to categorizations of hospitals beyond those related to their particular needs. We agree that providing clarity to support consumer decision-making should be a top priority; ignoring how consumers actually search will not achieve those ends. Supporting hospital quality improvement efforts, if a desired goal, could be addressed in non-public analyses of the ratings along the lines of the proposals under consideration. | Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery | <a href="mailto:fontanam@hss.edu">fontanam@hss.edu</a>                             | Medical University     | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | However, we believe that only three of the proposals should be pursued further at this time: ... 2) peer grouping star ratings using socio-economic factors (e.g., income, age, education, employment, uninsured and housing) among similar hospitals;...  | Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources   | <a href="mailto:joelballew@texashalth.org">joelballew@texashalth.org</a>           | Healthcare System      | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | I think differences in hospital characteristics could be handled through risk-adjustment (for risk-adjusted measures) or could be a filtering option in Hospital Compare but the star rating should continue to be compared to all hospitals. At this point I think that the best solution would be to have an additional column on the hospital compare website that shows the peer group result – I believe that NDNQI has options like this in its portal.  | Laura Morris, MS, CPHQ, Senior Business Analyst for Quality  | <a href="mailto:lmorris@glensfalls hosp.org">lmorris@glensfalls hosp.org</a>       | Individual             | Please refer to the Summary Report |
| 3/29/19     | Peer Grouping          | Performance across participating hospitals demonstrates clear bias towards lower ratings for teaching hospitals and safety net hospitals, as well as bias towards higher ratings for specialty hospitals and those reporting fewer measures. Peer groupings according to these features, presented in parallel with all-hospitals comparisons, will contribute to patient and consumer understanding of hospital performance.  | Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care  | <a href="mailto:hahncoverk@health.missouri.edu">hahncoverk@health.missouri.edu</a> | Medical University     | Please refer to the Summary Report |



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| 3/29/19     | Peer Grouping          | <p>CMS should examine ways to account for differences among hospitals to ensure the star ratings reflect actual quality of care within the control of the hospital. Peer grouping should only be used as a short-term strategy to address ratings bias until more appropriate risk adjustment can be incorporated into the ratings. If latent variable modeling is going to continue to be used in the star ratings, CMS should consider a two factor approach that includes one factor that addresses social risk. While dual eligibility is not a perfect measure of social risk, it is a readily available variable that could be used as part of a short-term strategy to better incorporate social risk into clinical outcomes. We have included a conceptual model of this (see Appendix).</p> <p><b>Appendix: A Conceptual Model That Incorporates Socioeconomic Status into CMS Star Rating Methodology</b></p> <p>The latent variable model takes a group of quality measures as its starting data. In order to illuminate how the latent variable is currently extracted and how that could plausibly improve in the future, we illustrate with data simplified to only three measures in the safety group and only ten hospitals:</p> <p><a href="#">[Table 18]</a></p> <p>The quality measures are standardized in terms of the number of standard deviations better than the national average, so that all quality measures are on the same scale.</p> <p><a href="#">[Table 19]</a></p> <p>If we naively sum the three quality measures, Hospital D looks the best and Hospital J looks the worst. Hospitals often do well on all three or poorly on all three, but when one quality measure is a different sign from the other two, the measure of opposite sign tends to be HAI-2. We say that HAI-2 doesn't correlate as well as the other two measures of quality. We will see shortly that this results in a smaller "loading" being assigned to HAI-2 during latent variable modeling. Since a bad hospital can sometimes have a good HAI-2 and good hospital can sometimes have a bad HAI-2, it is deemed to be a weak indicator of hospital quality. Mathematically, latent variable modeling is akin to data compression. We try to express a full matrix as a product between a single column and a single row:</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hennepinmed.org">Daniel.hoody@hennepinmed.org</a> | Healthcare System     | Please refer to the Summary Report |

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| 3/29/19     | Peer Grouping          | <p><a href="#">[Figure 12]</a><br/> where the column represents the loading of each measure and the row represents the hidden quality of each hospital. We choose the numbers that minimize the difference (according to a technical definition of error we won't go into) between the original matrix and the product of our row and column. For this data set, the optimal numbers happen to be</p> <p><a href="#">[Figure 13]</a><br/> A couple of surprising things have happened. Yes, Hospital D is top ranked as we naively expected, but Hospital B is not far behind despite a bad HAI-2 score. The latent variable modeling has decided PSI-90 is most indicative of quality, so Hospital B gets high overall marks due to a high PSI-90 score.<br/> Conversely, Hospital E has plummeted past Hospital J to the bottom of the pile due to a terrible PSI-90 score. Their positive performance in HAI-2 is mostly discounted.</p> <p>This raises the question of whether latent variable modeling is truly getting at some hidden truth by highlighting the most important quality measures, or whether it is arbitrarily (and unnecessarily) throwing away relevant data because that relevant data happens to correlate less well than other measures.</p> <p>Less us explore the theory that a dominant underlying cause of correlated quality measures is not the hidden treatment quality of a hospital so much as the social risk of the patients. Yes, some measures are risk adjusted, but it is plausible that the risk adjustments are not compensating for everything indicated by socio-economic status. Delancey[1] and Chatterjee[2] have shown that star ratings correlate negatively with the proportion of treated patients who have characteristics correlated with lower socioeconomic status. This should not happen if the single latent variable in each group is measuring only hospital quality; contrariwise it would happen if the latent variable is measuring both hospital quality and patient social risk that has not been fully risk-adjusted.</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hcm.org">Daniel.hoody@hcm.org</a> | Healthcare System      | Please refer to the Summary Report |

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|-------------|------------------------|--|--|--|-----------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>Fortunately, if it is really true that socioeconomic status is an important determiner of hospital outcomes, then latent variable modeling is ideally suited to separate out that factor and stop it from masking true treatment quality. To unearth the distinction, we can simply add dual eligibility as an additional measurable input indicative of socioeconomic status, and extracting a latent variable corresponding to dual eligibility before extracting the latent variable which is supposed to represent hospital quality.</p> <p><a href="#">[Table 20]</a></p> <p>If our expanded table of measures looked like the above table, we would suspect that we were on the right track. Note that the "bad" hospitals E and J both had a relatively large number of dual-eligible patients, which is our suspected hidden cause of poor outcomes. To quantify this, we can run a latent variable model with two factors, i.e.</p> <p><a href="#">[Figure 14]</a></p> <p>where we still think of Q as representing quality of the hospital, but now P has been added to represent patient social risk. One solution that minimizes error is</p> <p><a href="#">[Figure 15]</a></p> <p>The greatest loadings are associated with dual-eligibility, and while this data is hypothetical, it would not be surprising if real data also indicated that some hospital outcomes were more associated with socio-economic status of the patients than with other risk factors. Even with our hypothetical data, we still haven't quite achieved our aim of separating the influence of patient social risk from hospital quality, because dual-eligibility has a loading for both factors. Fortunately there are multiple, equally valid solutions that minimize error as required. We can "rotate" the latent variables so that one of them lines up exactly with dual-eligibility while the other latent variable is orthogonal to it.</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hcm.org">Daniel.hoody@hcm.org</a> | Healthcare System     | Please refer to the Summary Report |

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|-------------|------------------------|--|--|--|-----------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p><a href="#">[Figure 16]</a></p> <p>Now that the rotation is complete, the first column of loadings represents everything that correlates to treating dual-eligible patients while the second column of loadings represents everything that doesn't correlate to treating dual-eligible patients. In this hypothetical dataset, HAI-2 turns out to be more indicative of invisible treatment quality than the other two quality measures. This exact result wouldn't necessarily emerge from real data, but it illustrates the possibility that accounting for patient social risk could unmask a valuable indicator of treatment quality that is currently being discarded in one-factor modeling.</p> <p>The second row of the factor matrix now indicates hospital quality after patient social risk has been accounted for. Not everything has changed. Hospitals D and J, which we naively thought were the best and the worst respectively, remain the best and the worst in the two-factor analysis. But Hospital E has seen a huge change in rating. Instead of being branded as having horrible quality, they get credit for demonstrating slightly above average quality in treating a population with higher social risk. Meanwhile Hospital A, which got a decent rating both naively and in the one-factor model, turns out to have been giving sub-par treatment to patients with lower social risk.</p> <p>Hypothetical data proves nothing, of course, but given both the peculiarity of discounting quality measures that "bad" hospitals tend to be good at, and also the plausibility that the single-factor model is primarily picking up on correlations between quality measures and socio-economic status, it seems at least worth investigating how well it would work to use a two-factor model that attempts to compensate for the population being treated.</p> <p>1. Delancey, J.O., et al., Associations Between Hospital Characteristics, Measure Reporting, and the Centers for Medicare &amp; Medicaid Services Overall Hospital Quality Star Ratings. JAMA, 2017. 317(19): p. 2015-2017.</p> <p>2. Chatterjee, P. and K. Joynt Maddox, Patterns of performance and improvement in US Medicare's Hospital Star Ratings, 2016-2017. BMJ Qual Saf, 2018.</p> | Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare | <a href="mailto:Daniel.hoody@hennepin.org">Daniel.hoody@hennepin.org</a> | Healthcare System     | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment   | Name, Credentials, and Organization of Commenter                            | Email Address*   | Type of Organization *   | Response*                          |
|-------------|------------------------|---|---|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>NOSORH conducted a comprehensive analysis of the impact on rural hospitals of the December 2017 revised methodology used by the Centers for Medicare and Medicaid Services (CMS) in its Hospital Star Rating Program. NOSORH’s analysis looked at:</p> <ul style="list-style-type: none"> <li>• Rural urban differences in the percent of scored/unscored hospitals,</li> <li>• Rural-urban differences in the number of measures used in calculating a hospital score, and</li> <li>• Rural-urban differences in the number of domains used in calculating a hospital score.</li> </ul> <p>An additional review compared scoring under both the December 2017 and previous scoring methodologies for rural hospitals.</p> <p>The comprehensive analysis shows significant scoring differences between rural and urban hospitals, including troubling differences in the percentage of hospitals excluded from scoring and differences in the mix of measures used in scoring. These differences raise questions about how effective rural hospital quality measurement is under the CMS Hospital Star scoring methodology. A PowerPoint presentation summarizing NOSORH’s analysis of the December 2017 methodology is submitted as a separate document accompanying these comments. NOSORH has also conducted a preliminary analysis of the February 2019 methodology update to assess whether that methodology significantly changed the impact of the Hospital Star Rating Program on scoring for rural hospitals. This supplemental analysis repeated the examination of:</p> <ul style="list-style-type: none"> <li>• Rural urban differences in the percent of scored/unscored hospitals,</li> <li>• Rural-urban differences in the number of domains used in calculating a hospital score.</li> </ul> <p>The results of the supplemental analysis are summarized in a separate PowerPoint presentation accompanying these comments. This analysis shows no substantial change in the scoring of rural hospitals from December 2017 methodology. There is no reason to modify the findings of NOSORH’s comprehensive analysis on the effectiveness of the Hospital Star Rating Program for rural hospitals.</p> | Teryl Eisinger, CEO, National Organization of State Offices of Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment  | Name, Credentials, and Organization of Commenter                            | Email Address*   | Type of Organization*    | Response*                          |
|-------------|------------------------|--|---|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>Based on its analyses NOSORH makes specific recommendations about potential modification of the current Hospital Star Rating Program. The recommendations address how the current rating system could be modified to establish multiple hospital categories and peer grouping. This would lead to a rating system which would be more inclusive and meaningful for rural hospitals. NOSORH's recommendations are included at the end of these comments.</p> <p><b>Analysis Methodology</b></p> <p>Several data files were joined to create the datasets used for the comprehensive NOSORH analysis of the December 2017 methodology. The base file for the comprehensive analysis was a December 2017 Medicare hospital general information file. This file provided information about which hospitals were scored and which were unscored. In addition, the file provided information indicating which domains were used in calculating a scored hospital's performance. The base file was linked to a second file with USDA ERS Rural-Urban Continuum Codes (RUCCs) for United States counties. This file identifies several categories of rural and urban areas at the county or county equivalent level. A third file summarizing individual hospital reporting on all 57 measures was prepared using archived flat files for December 2017. Finally, an October 2017 Medicare hospital general information file was linked to the dataset to permit comparative analysis of the new methodology with the previous one.</p> <p>A similar approach was used for the analysis of the February 2019 methodology. The base file for the comprehensive analysis was a February 2019 Medicare hospital general information file. The base file was linked to a second file with USDA ERS Rural-Urban Continuum Codes (RUCCs) for United States counties. The use of an identical analytic approach permits comparison of the rural impact of the December 2017 and February 2019 analyses.</p> <p>Both NOSORH analyses were conducted using the SAS Institute JMP software. Urban/rural hospital reporting and scoring results were compared. Separate CAH analyses were also prepared.</p> | Teryl Eisinger, CEO, National Organization of State Offices of Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment  | Name, Credentials, and Organization of Commenter                                     | Email Address*   | Type of Organization*    | Response*                          |
|-------------|------------------------|--|--|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p><b>Key Analysis Findings</b></p> <p><b>Rural Hospital Scoring Under the December 2017 Methodology:</b></p> <ul style="list-style-type: none"> <li>o The percentage of unscored rural hospitals was much higher than unscored urban hospitals. <a href="#">[Figure 17]</a> 33% of all rural hospitals in the base file were unscored – more than twice the 15% figure for unscored urban hospitals. In addition, more than half (52%) of all Critical Access Hospitals in the base files were unscored <a href="#">[Figure 18]</a>. This suggests that many rural hospitals were unable to meet the minimum reporting requirements for scoring, and that the set of measures used for scoring is a poor fit for their operations.</li> <li>o The star result for scored rural hospitals was based upon a significantly lower number of measures than was the star result of urban hospitals. On average, scored rural hospitals reported only 35 measures while scored urban hospitals reported 46 measures <a href="#">[Figure 19]</a>. This disparity extended to domains upon which the star result was calculated. 77% of scored urban hospitals had a star result based upon all 7 domains, compared to only 37% of scored rural hospitals <a href="#">[Figure 20]</a>. This highlights the fact that urban and rural hospitals are being scored on very different sets of measures.</li> </ul> <p>A more detailed discussion of findings can be found in the accompanying presentation beginning on slide 12.</p> <p><b>Comparative Rural Hospital Scoring Under December 2017 Methodology and Previous Methodology:</b> <a href="#">[Figure 21]</a></p> <ul style="list-style-type: none"> <li>o Under the December 2017 star rating methodology: <ul style="list-style-type: none"> <li>▪ The relative percentage of unscored rural hospitals declined.</li> <li>▪ The relative percentage of 3-Star rated rural hospitals declined.</li> <li>▪ The relative percentage of 4-Star and 5-Star rated rural hospitals increased, as did the relative percentage of 1-Star and 2-Star rated rural hospitals.</li> </ul> </li> <li>o The December 2017 methodology had a substantial impact on the distribution of ratings in 2 Measure Groups/Domains: <ul style="list-style-type: none"> <li>▪ <a href="#">[Figure 22]</a> Safety of Patient Care, and</li> <li>▪ <a href="#">[Figure 23]</a> Readmission.</li> </ul> </li> </ul> | Teryl Eisinger, CEO,<br>National Organization<br>of State Offices of<br>Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment  | Name, Credentials, and Organization of Commenter                                     | Email Address*   | Type of Organization *   | Response*                          |
|-------------|------------------------|--|--|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>This redistribution was significant for both rural and urban hospitals.</p> <ul style="list-style-type: none"> <li>o The December 2017 methodology had a smaller impact on the distribution of ratings in the other 5 Measure Groups/Domains.</li> </ul> <p>A more detailed discussion of these findings can be found in the presentation beginning on slide 7.</p> <p><b>Rural Hospital Scoring Under the February 2019 Methodology:</b></p> <ul style="list-style-type: none"> <li>o The percentage of unscored rural hospitals was much higher than unscored urban hospitals. 30.7% of all rural hospitals in the base file were unscored – more than twice the 12.2% figure for unscored urban hospitals. In addition, almost half (47.7%) of all Critical Access Hospitals in the base files were unscored. This suggests that many rural hospitals continue to be unable to meet the minimum reporting requirements for scoring under the February 2019 methodology. The set of measures used for scoring continues to be a poor fit for rural hospital operations.</li> <li>o Only 19.6% of scored rural hospitals were rated 1 or 2 stars. This was substantially lower than the 34.0% of scored urban hospitals with these lesser ratings. 40.0% of scored rural hospitals were rated 4 or 5 stars. This was higher than the 35.6% of scored urban hospitals with these better ratings. 40.4% of scored rural hospitals were rated 3 stars. This was significantly higher than the 30.5% of scored urban hospitals with this mid-line rating.</li> <li>o The star result for scored rural hospitals was based upon a significantly lower number of domains than was the star result of urban hospitals. 77.8% of scored urban hospitals had a star result based upon all 7 domains, compared to only 38.0% of scored rural hospitals. In addition, the star result for 12.8% of scored rural hospitals were based on only 3 domains compared to only 4.6% of scored urban hospitals. This highlights the fact that urban and rural hospitals are being scored on very different sets of measures.</li> <li>o Only 5.4% of scored CAHs were rated as 1-star or 2-star hospitals. This is compared to 30.5% of scored acute care hospitals in these rating categories.</li> <li>o Only 2% of scored Critical Access Hospitals (CAHs) have ratings based on measures in all 7 domains. This compares with 78.3% of scored acute care hospitals. In addition, 60.2% of scored CAHs have ratings based on only 3 or 4 measurement domains. This compares with 6.4% of scored acute care hospitals.</li> </ul> | Teryl Eisinger, CEO,<br>National Organization<br>of State Offices of<br>Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |



| Date Posted | Measure Set or Measure | Text of Comment  | Name, Credentials, and Organization of Commenter                            | Email Address*   | Type of Organization*    | Response*                          |
|-------------|------------------------|--|---|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>Note that only 2.3% of CAHS are scored on the Patient Safety Domain, indicating that this is a substantial problem for the rating methodology. Scored rural hospitals have higher ratings, as a group, than do scored urban hospitals. This may not be the result of better-quality operations. It may instead be an artifact of the different mix of measures being used in the calculation of rural hospital scores. A more detailed discussion of findings can be found in the accompanying presentation.</p> <p><b>Recommendations for Improved Rural Hospital Quality Scoring:</b></p> <p>Overview: NOSORH has prepared several recommendations for how CMS could improve the usefulness of the Star Rating Program for rural hospitals. These recommendations suggest how the single rating system for all hospitals might be disaggregated into a more useful multi-category rating system for comparable subsets of hospitals. The resulting multi-category system would be something akin to the hospital rating system developed for US News and World Reports. While that system is more complex than would be needed by CMS, it demonstrates the usefulness of a multi-category approach:</p> <p><a href="https://health.usnews.com/best-hospitals/rankings">https://health.usnews.com/best-hospitals/rankings</a></p> <p>A multi-category system could also incorporate a separate approach for rural hospitals consistent with the NQF Final Report on Rural-Relevant Quality Measures:</p> <p><a href="http://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx">http://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx</a></p> <p><b>Recommendation 1: Multi-Category Hospital Rating System</b></p> <p>Create Multiple Hospital Scoring Categories: NOSORH recommends that CMS establish several separate sets of measures for hospitals based upon services provided and operational characteristics. Each category should have a mix of measures appropriate for the hospitals included – measures for which the hospitals can meet the minimum reporting requirements. This approach would reduce instances of non-reporting by hospitals – for example, when hospitals without orthopedic services reports are asked to report on joint replacement outcomes. The approach would also minimize any reweighting of scores necessitated by low volume non-reporting. Each hospital category could include a core set of cross-cutting measures applicable to all facilities.</p> | Teryl Eisinger, CEO, National Organization of State Offices of Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment   | Name, Credentials, and Organization of Commenter                                     | Email Address*   | Type of Organization *   | Response*                          |
|-------------|------------------------|---|--|--|--------------------------|------------------------------------|
| 3/29/19     | Peer Grouping          | <p>Measures in all categories should risk adjusted for hospitals such as Disproportionate Share Hospitals, Sole Community Hospitals and other facilities with larger percentages of low-income patients and uninsured patients. This could be done in a manner consistent with the principles set out by the National Quality Forum in its examination of risk adjustment for socioeconomic factors in quality assessment:</p> <p><a href="http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx">http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx</a></p> <p>Critical Access Hospitals (CAHs) should likely have its own category. The high percentage of CAHs not scored under the current schema points toward the need for a specific set of measures and reporting minimums appropriate for the measurement of quality in their operations. The Medicare Beneficiary Quality Improvement Project (MBQIP) measure set, currently in use for CAHs, can form the basis of this measurement Category. This measure set is supported by the Federal Office of Rural Health Policy and has a multi-year history:</p> <p><a href="https://www.ruralcenter.org/tasc/mbqip">https://www.ruralcenter.org/tasc/mbqip</a></p> <p><b>Recommendation 2: Hospital Peer Groups</b></p> <p>Create Multiple Hospital Peer Groups for Additional Comparisons: NOSORH recommends that CMS create peer groups of hospitals for purposes of comparison. Multiple peer groups can be created within each broad hospital measurement category, using an approach similar to the county peer groups used for health status measurement in the County Health Rankings project sponsored by the Centers for Disease Control and Prevention:</p> <p><a href="http://www.countyhealthrankings.org/peer-counties-tool">http://www.countyhealthrankings.org/peer-counties-tool</a></p> <p>Peer hospital groups can reflect the size and location of hospitals as well as patient population risk similarities. This would allow hospitals to compare themselves not only to a broader hospital category, but to a smaller group of hospitals with similar characteristics. For example, within a CAH category, a CAH with 10 beds and no surgical services or swing beds could compare its operations and ranking to similar CAHs with smaller bed capacity and limited service mix.</p> | Teryl Eisinger, CEO,<br>National Organization<br>of State Offices of<br>Rural Health | <a href="mailto:teryle@nosorh.org">teryle@nosorh.org</a> | Professional Association | Please refer to the Summary Report |

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|-------------|------------------------|--|--|--|------------------------|------------------------------------|
| 3/29/2019   | Peer Grouping          | -Risk-adjust measures for socioeconomic status and stratify hospitals based on applicable peer groups<br>-Develop star ratings for general hospitals based on a data set of general hospitals only, but continue to develop star ratings for specialty hospitals using data from all eligible hospitals  | Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a> | Hospital Association   | Please refer to the Summary Report |
| 3/29/2019   | Peer Grouping          | Peer Grouping<br>CMS requests feedback on peer grouping hospitals based on characteristics such as dual-eligible shares, teaching status, bed size, number of measures, and specialty/non-specialty hospital. GNYHA supports peer grouping as a mechanism to address the widespread concerns about potential bias in the current star ratings by comparing hospital performance against “peer” hospitals. In particular, as we have noted in prior comment letters, we are concerned that teaching hospitals (which generally report on more measures than non-teaching hospitals) and safety net hospitals treating larger proportions of low-income patients, on average, have lower star ratings. There is precedent for peer grouping—CMS already uses risk-stratification to group hospitals by dual-eligible shares for purposes of Medicare Hospital Readmissions Reduction Program (HRRP) penalties—and it is an approach that could easily be adopted for the star ratings. However, we caution CMS against displaying multiple star ratings (i.e., results by multiple peer group types) for individual hospitals, which would only confuse consumers because the ratings for individual hospitals would likely be different across various peer groups. To address this concern, CMS should limit the number of characteristics it considers for this purpose and prioritize those factors outside of a hospital’s control that are known to influence the star rating, such as socioeconomic status and number of reported measures (we note that these factors could be blended to create peer groups). | Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a> | Hospital Association   | Please refer to the Summary Report |

| Date Posted | Measure Set or Measure | Text of Comment  | Name, Credentials, and Organization of Commenter  | Email Address*                                       | Type of Organization * | Response*                          |
|-------------|------------------------|--|---|--|------------------------|------------------------------------|
| 3/29/2019   | Peer Grouping          | <p>In addition, we have observed that general hospitals are under-represented relative to specialty hospitals among hospitals with five-star ratings because of the structure of the public reporting thresholds. While we support the development of star ratings for specialty hospitals, we believe that there needs to be differentiation between specialty hospitals and general hospitals to reflect the differences in patient care needs and patient populations served. Therefore, we recommend that CMS classify each hospital as either a general hospital or specialty hospital and compute star ratings for each group as follows:</p> <ol style="list-style-type: none"> <li>1. General Hospitals. For general hospitals, star ratings should be derived from data for general hospitals, where general hospitals are those with publicly reported mortality rates for heart failure and pneumonia.</li> <li>2. Specialty Hospitals. For specialty hospitals, star ratings should be derived from data, with all hospitals eligible for a star rating with an asterisk or an indicator for hospitals that are not identified as general hospitals.</li> </ol> <p>This approach has the added benefit of addressing bias for hospitals with missing data. In hospitals with star ratings that do not include the mortality domain, 91% (359 hospitals) receive star ratings of three or above compared to 69% in hospitals with star ratings that include the mortality domain. Our proposed risk-stratification method addresses this issue by defining general hospitals as those with available mortality data.</p> <p>Finally, while GNYHA supports peer grouping, we see this as an interim solution to improving the star ratings' validity. We strongly encourage CMS to continue its research on methodologies to risk-adjust quality measures, particularly for socioeconomic status in order to avoid disadvantaging hospitals caring for socially at-risk communities. This would improve the validity not only of this program, but the Medicare performance-based payment systems as well.</p> | Elisabeth R. Wynn,<br>Executive Vice President,<br>Health Economics &<br>Finance, Greater New<br>York Hospital<br>Association | <a href="mailto:achin@gnyha.org">achin@gnyha.org</a> | Hospital Association   | Please refer to the Summary Report |

# Appendix. Overall Hospital Quality Star Ratings Public Input Figures and Tables

Overall Project and Methodology

Table 1. American Hospital Association- Assessment of How Proposed Star Ratings Changes Address “Must Have” Design Elements

|   |  | Useful to consumers      | Accuracy                 | Stability                | Line of sight to underlying measures | Balanced assessment      | Accounts for potential bias | Pursue Further? |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|-----------------------------|-----------------|
| Proposed Short-term changes to existing methodology | Update star ratings once per year                                      | Insufficient information | No                       | Partially                | No                                   | No                       | No                          | ✗               |
|   | New empirical criteria for creating and monitoring measure groups      | No                       | Partially                | Partially                | No                                   | Partially                | No                          | ✓               |
|   | Divide safety measure group into medical and surgical safety subgroups | No                       | No                       | Partially                | No                                   | Partially                | No                          | ✗               |
|   | Use individual component PSI* measures                                 | No                       | No                       | No                       | No                                   | No                       | No                          | ✗               |
|   | Confidence interval-based measure weights                              | No                       | No                       | No                       | No                                   | Partially                | No                          | ✗               |
|   | Logarithm of denominator-based weights                                 | No                       | Insufficient information | Insufficient information | No                                   | Insufficient information | No                          | ✗               |
|   | Eliminate denominator weights  | No                       | No                       | No                       | No                                   | Partially                | No                          | ✗               |
|   | Peer grouping  | Partially                | Partially                | No                       | No                                   | No                       | Partially                   | ✓               |
|   | Weighted-average summary scores (e.g., combine two reporting periods)  | No                       | No                       | Partially                | No                                   | No                       | No                          | ✗               |
|   | Closed form computational method for latent variable model             | Insufficient info        | Insufficient information | Insufficient information | Insufficient information             | Insufficient information | Insufficient information    | ✗               |
| Proposed Long-term changes                          | Stop using LVM** and adopt an explicit approach to star ratings        | Partially                | Insufficient information | Partially                | Yes                                  | Partially                | Insufficient information    | ✓               |
|   | Move away from K-means clustering                                      | Insufficient information | Insufficient information | Insufficient information | Yes                                  | No                       | No                          | ✗               |
|   | Account for improvement over time                                      | No                       | No                       | Partially                | No                                   | No                       | No                          | ✗               |
|   | User-customized star ratings   | Partially                | No                       | No                       | No                                   | Partially                | No                          | ✗               |

\*PSI = Patient Safety Indicator \*\*LVM = latent variable model

Table 2. Adventist Health Lodi Memorial-Lodi Memorial Hospital Association Measure Results

|  |   |
|--|---|
| <b>Overall STAR Rating</b>                             | <b>2</b>  |
| <b>Patient Experience</b>                              | <b>3</b>  |
| <b>Timely &amp; Effective Care</b>                     | <b>2</b>  |
| Sepsis   | scored above California & Nat'l average   |
| Cataract Surgery                                       | N/A   |
| Colonoscopy  | scored 100% for follow up screening   |
|  | too few cases for hx polyps   |
| Heart Attack Care                                      | transferred to another hospital faster than California & Nat'l average              |
|  | Time to EKG better than California, <b>1 min slower than Nat'l</b>                  |
|  | TPA w/l 30 min--no cases qualified  |
|  | ASA for CP/AMI scored higher than California & Nat'l                                |
| Emergency Dept Care                                    | Time to pain management for long bone fx faster than California & Nat'l             |
|  | Left without being seen--Lower percentage of patients than California & Nat'l       |
|  | Stroke brain scan results in 45 min-- <b>rate lower than California &amp; Nat'l</b> |
|  | Time in ED before admit-- <b>longer than nat'l</b> , shorter than California        |
|  | Time in ED after decision to admit--shorter than California & Nat'l                 |
|  | Time in ED for discharged pts-- <b>longer than California &amp; Nat'l</b>           |
|  | Time until seen by healthcare professional--shorter than California & Nat'l         |
| Influenza vaccines                                     | Patients--rate higher than California & Nat'l                                       |
|  | Employees-- <b>rate lower than California &amp; Nat'l</b>                           |
| Cancer care  | N/A   |
| Blood clot prevention                                  | Too small to report   |
| Pregnancy/Delivery                                     | Scheduled for early delivery-- <b>rate higher than California &amp; Nat'l</b>       |
| <b>Complications &amp; Deaths</b>                      | <b>2</b>  |
| Hip/Knee complications                                 | No different than nat'l   |
| Serious complications                                  | No different than nat'l   |
| Deaths after surgery w/serious treatable complications | No different than nat'l   |
| Infections   |   |
| CLABSI   | No different than nat'l   |
| CAUTI  | No different than nat'l   |
| SSI - colon surg                                       | No different than nat'l   |
| SSI - abd hyster                                       | No infections reported  |
| MRSA blood infections                                  | No different than nat'l   |
| C-diff   | No different than nat'l   |
| 30-day death rate                                      | No different than nat'l in all areas except CABG which is not done at AHLM          |

Table 3. Vizient- February 2019 CMS Latent Variable Modeling Assessment

| Groups                | Goodness of Fit <sup>1</sup> | Root Mean Square Error Approximation <sup>2</sup> | Comparative Fit Index <sup>3</sup> | Standardized Root Mean Square Residual <sup>4</sup> | # of Statistical Assessments Indicating Modeling Opportunity |
|-----------------------|------------------------------|---|------------------------------------|---|--|
| Mortality             | 60%                          | 0.0357  | 0.9658                             | 0.0543  | 1/4  |
| Readmission           | 100%                         | 0.0622  | 0.9093                             | 0.0647  | 2/4  |
| Safety                | 64%                          | 0.0372  | 0.7601                             | 0.0724  | 3/4  |
| Patient Experience    | 100%                         | 0.2122  | 0.8546                             | 0.0502  | 3/4  |
| Efficiency            | 17%                          | 0.0367  | 0.9349                             | 0.0512  | 0/4  |
| Process Timeliness    | 100%                         | 0.1544  | 0.8807                             | 0.1320  | 4/4  |
| Process Effectiveness | 100%                         | 0.0493  | 0.7624                             | 0.0881  | 3/4  |

\*Vizient model fit statistics were generated using 1-factor, non-weighted latent variable instead of 1-factor, weighted, due to limited model fit analysis provided by CMS

Table 4. Vizient- Hospitals Penalized in the CMS Pay-for-Performance Programs versus the February 2019 Hospital Star Rating ‘Above National Average’ and Overall 5-Star Performance

| CMS P4P FY 2019 Program Penalty | Total Hospitals Penalized | National Comparison Group                 | Above the National Average | Overall 5 Star Rating |
|---------------------------------|---------------------------|---|----------------------------|-----------------------|
| VBP                             | 1229                      | Mortality<br>Safety<br>Patient Experience | 105<br>452<br>151          | 6<br>25<br>12         |
| HACRP                           | 800                       | Safety                                    | 161                        | 27                    |
| HRRP                            | 2587                      | Readmission                               | 945                        | 132                   |

Table 5. Vizient- December 2017 Measure Loading Coefficients

| Parameter  | Estimate | Standard Error | Pr >  t |
|--|----------|----------------|---------|
| Central-Line Associated Bloodstream Infection (CLABSI)                           | 0.01836  | 0.01149        | 0.11    |
| Catheter-Associated Urinary Tract Infection (CAUTI)                              | 0.00095  | 0.0107         | 0.9308  |
| Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy) | 0.04736  | 0.02416        | 0.0501  |
| Clostridium Difficile (C. difficile)   | 0.01161  | 0.008501       | 0.1719  |

Figure 1. Vizient- AMC February 2019 Star Rating Distribution Comparison with Vizient Proposed Methodology

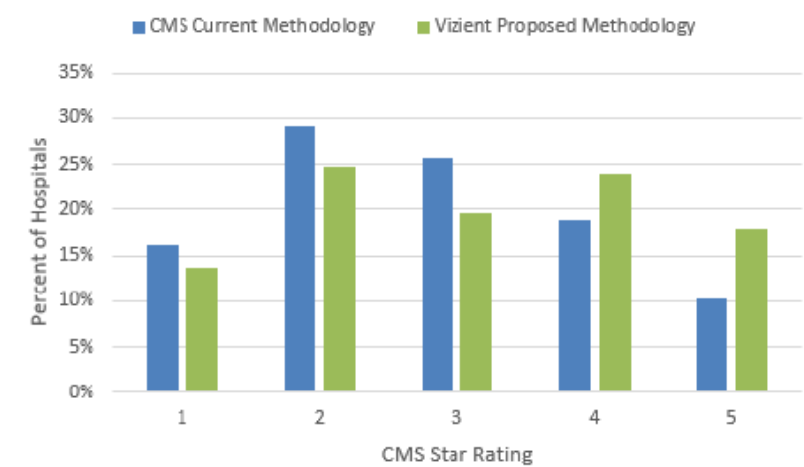
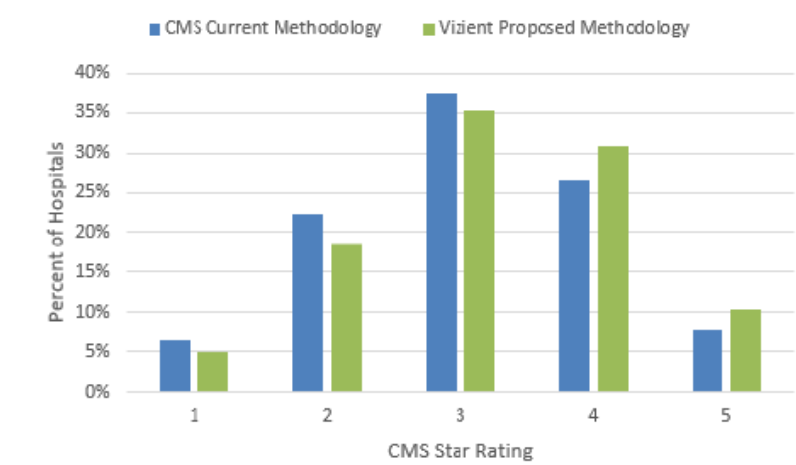




Figure 2. Vizient- Community February 2019 Star Rating Distribution Comparison with Vizient Proposed Methodology



February 2019 Methodology Updates

Table 6. Vizient- Readmission Group February 2019 Measure Loading Coefficients (data published in CMS February Report)

| Measure  | Loading Coefficient |
|--|---------------------|
| Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction  | 0.338               |
| Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate  | 0.3154              |
| Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate   | 0.5515              |
| Excess Days in Acute Care after Hospitalization for Heart Failure  | 0.4544              |
| Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) | 0.4107              |
| Excess Days in Acute Care after Hospitalization for Pneumonia (PN)   | 0.4372              |
| Stroke (STK) 30-Day Readmission Rate   | 0.5306              |
| HWR Hospital-Wide All-Cause Unplanned Readmission  | 0.9976              |
| Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy  | -0.01311            |

Table 7. Vizient- Comparing Safety Group Loading Coefficients Over Time

| Measures  | Feb 2019 | July 2018 (not released) | Dec 2017 | Oct 2017 | Dec 2016 | Oct 2016 | Jul 2016 | Apr 2016 | Apr 2015 |
|---|----------|--------------------------|----------|----------|----------|----------|----------|----------|----------|
| PSI-90-Safety   | 0.90060  | 0.16520                  | 0.94420  | 0.920    | 0.930    | 0.930    | 0.780    | 0.920    | 0.770    |
| Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) | 0.19730  | 0.96400                  | 0.21100  | 0.210    | 0.170    | 0.170    | 0.680    | 0.190    | 0.560    |
| Central-Line Associated Bloodstream Infection (CLABSI)  | 0.00600  | 0.02421                  | 0.01836  | 0.030    | 0.050    | 0.060    | 0.100    | 0.070    | 0.020    |
| Catheter-Associated Urinary Tract Infection (CAUTI)   | 0.00744  | -0.00400                 | 0.00094  | 0.010    | 0.050    | 0.110    | 0.090    | 0.110    | 0.100    |
| Surgical Site Infection from colon surgery (SSI-colon)  | 0.04659  | -0.04424                 | 0.04946  | 0.050    | 0.120    | 0.090    | 0.050    | 0.090    | 0.100    |
| Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)  | 0.06504  | -0.01476                 | 0.04735  | 0.020    | 0.060    | 0.060    | 0.070    | 0.080    | 0.090    |
| MRSA Bacteremia   | 0.03680  | 0.03397                  | 0.07112  | 0.080    | 0.020    | 0.010    | 0.560    | 0.030    | 0.050    |
| Clostridium Difficile (C.difficile)   | 0.02582  | 0.02580                  | 0.01161  | 0.020    | 0.030    | 0.001    | 0.770    | 0.000    | 0.070    |

Table 8. Vizient- Vizient Simulated December 2017 Star Ratings versus CMS Published December 2017 Star Rating Comparison (Vizient Analysis using December 2017 CMS data)

| Vizient updated December 2017 Analysis |        |        |        |        |        |       |
|--|--------|--------|--------|--------|--------|-------|
| CMS December 2017<br>Star Rating       | Star-1 | Star-2 | Star-3 | Star-4 | Star-5 | Total |
|  | Star-1 | 261    | 0      | 0      | 0      | 261   |
|  | Star-2 | 0      | 752    | 0      | 0      | 752   |
|  | Star-3 | 0      | 0      | 1188   | 1      | 1189  |
|  | Star-4 | 0      | 0      | 0      | 1153   | 1153  |
|  | Star-5 | 0      | 0      | 0      | 0      | 336   |
|  | Total  | 261    | 752    | 1188   | 1154   | 336   |
|  |        |        |        |        |        | 3691  |

Table 9. Vizient- Safety Group Measure Loading Coefficient Comparison: Vizient Simulated versus December 2017 Published (CMS December 2017 Star Publically Available Data Set)

| Measures  | Dec 2017 | Updated Dec 2017* | Difference |
|---|----------|-------------------|------------|
| PSI-90-Safety   | 0.94420  | 0.944073          | -0.0001    |
| Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) | 0.21100  | 0.210817          | -0.0002    |
| Central-Line Associated Bloodstream Infection (CLABSI)  | 0.01836  | 0.022699          | 0.0043     |
| Catheter-Associated Urinary Tract Infection (CAUTI)   | 0.00094  | 0.002411          | 0.0015     |
| Surgical Site Infection from colon surgery (SSI-colon)  | 0.04946  | 0.045498          | -0.0040    |
| Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)  | 0.04735  | 0.045425          | -0.0019    |
| MRSA Bacteremia   | 0.07112  | 0.061520          | -0.0096    |
| Clostridium Difficile (C.difficile)   | 0.01161  | 0.016985          | 0.0054     |

Measure Grouping

Figure 3. Rush University Medical Center- Safety Doman Score vs. Standardized PSI-90 – Feb 2019

Safety Domain Score vs Standardized PSI-90 - Feb 2019

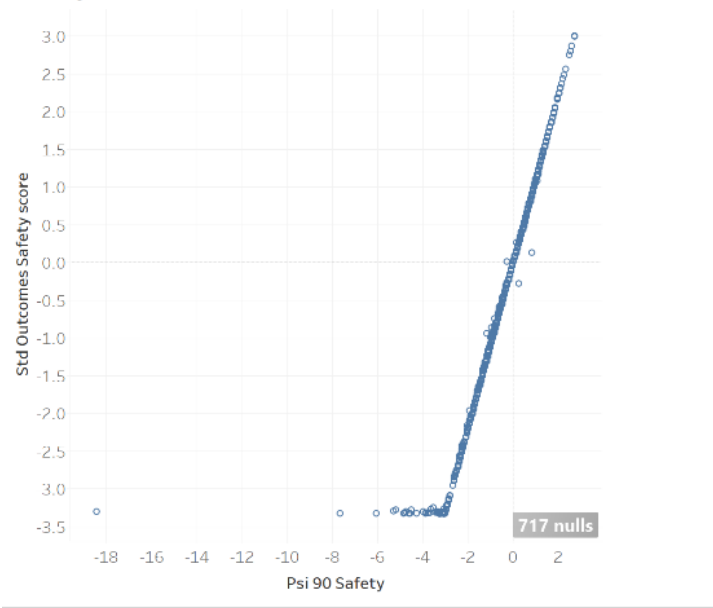


Figure 4. Rush University Medical Center- Safety Domain Score vs. Standardized C. Diff.- Feb 2019

Safety Domain Score vs Standardized C.Diff - Feb 2019

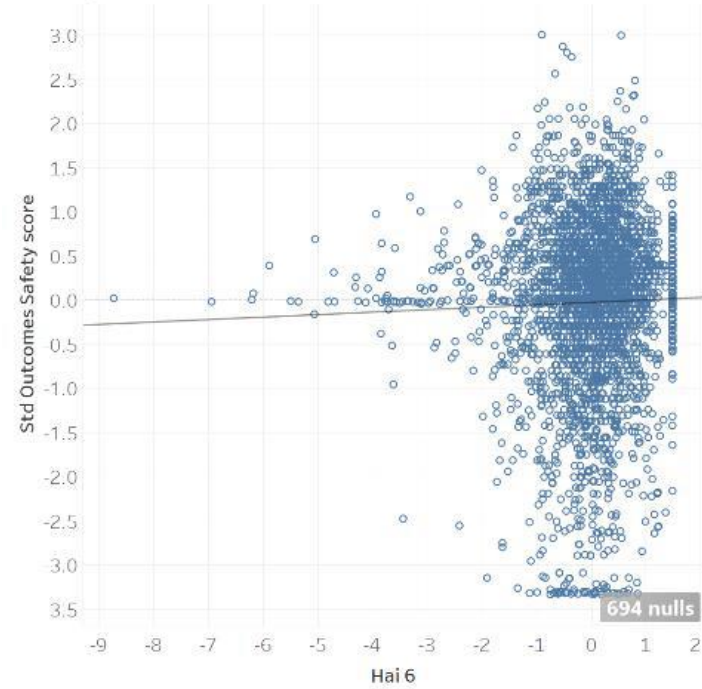
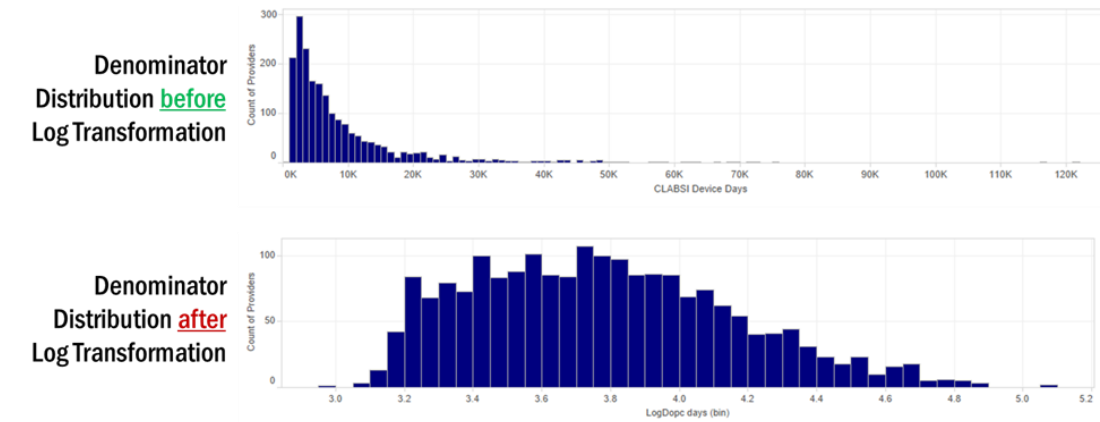


Table 10. Greater New York Hospital Association-Proposed Approach to Peer Grouping

| Proposed Approach to Regrouping      | Description  |
|--------------------------------------|--|
| Step 1. Initial Clinical Grouping    | Apply existing measure inclusion criteria and group measures based on clinical coherence   |
| Step 2. Confirmatory Factor Analysis | Assess whether a single underlying factor is associated with all measures in the group based on: <ul style="list-style-type: none"><li>Ratio of eigenvalues of the first to second is greater than 3</li><li>Qualitative assessment of the eigenvalue scree plot</li></ul> |
| Step 3. Ongoing Active Monitoring    | Periodically assess measure groups to confirm measure loading balance and consistency over time  |

Incorporating Measure Precision

Figure 5. Healthcare Association of New York State- Denominator Distribution Before and After Log Transformation



Period-To-Period Shifts

Table 11. Rush University Medical Center- Change in Loadings Over Time and the Shift During the June 2018 (un)release

| Measure Group  | Measure ID    | Measure Name  | Feb 19 | Jun 18 (Not Released) | Dec 17 | Oct 17 | Dec 16 |
|----------------|---------------|---|--------|-----------------------|--------|--------|--------|
| Safety of Care | HAI-1         | Central-Line Associated Bloodstream Infection (CLABSI)  | 0.01   | 0.02                  | 0.02   | 0.03   | 0.05   |
| Safety of Care | HAI-2         | Catheter-Associated Urinary Tract Infection (CAUTI)   | 0.007  | -0.004                | 0.001  | 0.01   | 0.05   |
| Safety of Care | HAI-3         | Surgical Site Infection from colon surgery (SSI-colon)  | 0.05   | -0.04                 | 0.05   | 0.05   | 0.12   |
| Safety of Care | HAI-4         | Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)  | 0.07   | -0.01                 | 0.05   | 0.02   | 0.06   |
| Safety of Care | HAI-5         | MRSA Bacteremia   | 0.04   | 0.03                  | 0.07   | 0.08   | 0.02   |
| Safety of Care | HAI-6         | Clostridium Difficile (C.difficile)   | 0.03   | 0.03                  | 0.01   | 0.02   | 0.03   |
| Safety of Care | COMP-HIP-KNEE | Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) | 0.20   | 0.96                  | 0.21   | 0.21   | 0.17   |
| Safety of Care | PSI-90-Safety | Patient Safety for Selected Indicators (PSI)  | 0.90   | 0.17                  | 0.94   | 0.92   | 0.93   |

Peer Grouping

Table 12a. Rush University Medical Center-Changes to Overall Rating from SES Inclusion

| Hospital                                     | % Dual Eligible | Original Star | SES Corrected Star |
|--|-----------------|---------------|--------------------|
| Rush University Medical Center               | 31%             | 5*            | 5                  |
| University of Chicago Hospital               | 36%             | 3             | 4                  |
| John H. Stroger, Jr. Hospital of Cook County | 53%             | 1             | 2                  |



Table 12b. Rush University Medical Center -Changes to Overall Rating from SES Inclusion

| Hospital                    | % Dual Eligible | Original Star | SES Corrected Star |
|-----------------------------|-----------------|---------------|--------------------|
| Centegra Hospital – McHenry | 13%             | 5             | 4                  |
| Advocate Good Samaritan     | 11%             | 4             | 3                  |
| AMITA Health Adventist      | 10%             | 5             | 4                  |

Figure 6. Centers for Medicare and Medicaid Services

1. Teaching

a. General

A. Urban

2. Acute

b. Specialty

3 Psych
- HOSPITALS
1. CAHs

B. Rural

2. Sole Community Hospitals/Rural referral hospitals

Table 13. Missouri Hospital Association- Hospital Overall Star Ratings by Sociodemographic Status

| Table 1<br>Hospital Overall Star Ratings by Sociodemographic Status |  | 1 Star   | 2 Star   | 3 Star   | 4 Star   | 5 Star   | 1 Star vs. 5 Star % Difference |
|---|--|----------|----------|----------|----------|----------|--------------------------------|
| Home ZIP Code-Level   | Unemployment Rate <sup>1</sup>                     | 12.68    | 11.30    | 9.32     | 8.54     | 7.47     | 69.7%                          |
|   | Percent Non-white <sup>1</sup>                     | 46.04    | 32.56    | 22.33    | 18.81    | 24.06    | 91.3%                          |
|   | Percent Age 25+ Less Than High School <sup>1</sup> | 17.58    | 16.50    | 14.97    | 12.01    | 9.16     | 91.9%                          |
|   | Poverty Rate <sup>1</sup>                          | 18.14    | 15.77    | 13.19    | 11.10    | 10.23    | 77.4%                          |
|   | Childhood Poverty Rate <sup>1</sup>                | 27.51    | 24.48    | 21.17    | 18.14    | 16.39    | 67.8%                          |
|   | Median Household Income <sup>1</sup>               | \$47,248 | \$46,982 | \$48,367 | \$53,911 | \$58,501 | -19.2%                         |
|   | Residential Vacancy Rate <sup>1</sup>              | 12.25    | 11.87    | 13.48    | 12.15    | 9.90     | 23.8%                          |
|   | SED Index <sup>1</sup>                             | 0.46     | 0.31     | 0.13     | -0.10    | -0.26    | 276.9%                         |
| Patient Mix-Level   | SSI Ratio <sup>2</sup>                             | 1,349    | 952      | 566      | 488      | 361      | 274.2%                         |
|   | DSH Percent <sup>3</sup>                           | 0.48     | 0.36     | 0.30     | 0.23     | 0.13     | 279.6%                         |
|   | Uncompensated Care per Claim <sup>3</sup>          | \$3,801  | \$1,028  | \$867    | \$577    | \$170    | 2132.7%                        |

Sources: Hospital Industry Data Institute calculations of CMS star ratings data for all hospitals used in the star calculations (i.e., not just those meeting reporting criteria) merged with 2015 Nielsen PopFacts Premier data (1), the 2016 CMS INPpsf1601 file (2) and FY 2017 CMS Final Rule Impact File Data (3). Note: The hospital ZIP code socioeconomic deprivation (SED) index is the mean Z-score of the Nielsen variables presented in the table with home value and household income scaled by -1 to maintain additivity.

Table 14. Missouri Hospital Association- Hospital Overall Star Ratings by Hospital Characteristics

| Table 2<br>Hospital Overall Star Ratings by Hospital Characteristics |   | 1 Star | 2 Star | 3 Star | 4 Star | 5 Star | 1 Star vs. 5 Star % Difference |
|--|---|--------|--------|--------|--------|--------|--------------------------------|
| Data Availability  | # Domains (of 7) <sup>1</sup>                           | 6.6    | 6.6    | 5.7    | 6.4    | 5.8    | 15.2%                          |
|  | # Measures (of 64) <sup>1</sup>                         | 50.4   | 47.9   | 33.7   | 42.7   | 36.2   | 39.3%                          |
| Volume and Severity  | Staffed Beds <sup>2</sup>                               | 310    | 247    | 170    | 176    | 131    | 136.5%                         |
|  | Average Census <sup>2</sup>                             | 204    | 151    | 93     | 99     | 69     | 193.9%                         |
|  | Transfer-Adjusted Cases <sup>2</sup>                    | 3,468  | 3,429  | 2,422  | 2,830  | 2,324  | 49.3%                          |
|  | Outlier Payment % Total Operating Payments <sup>2</sup> | 6.2%   | 4.3%   | 4.4%   | 4.1%   | 2.6%   | 134.8%                         |
|  | % Large Urban <sup>2</sup>                              | 63.1%  | 42.1%  | 22.9%  | 32.0%  | 33.1%  | 90.9%                          |

Sources: Hospital Industry Data Institute calculations of CMS star ratings data for all hospitals used in the star calculations (i.e., not just those meeting reporting criteria) (1), and for IPPS hospitals merged with the FY 2017 CMS Final Rule Impact File Data (2).

Table 15. Missouri Hospital Association- Summary Findings of CMS Overall Hospital Star Rating Sensitivity Analysis

| Table 3<br>Summary Findings of CMS<br>Overall Hospital Star Rating<br>Sensitivity Analysis |                | Base CMS<br>Model |        | Complete<br>Domain Model |        | PSI-90 Exclusion<br>Model |        | HWR Exclusion<br>Model |        | Complete Domain,<br>PSI-90 and HWR<br>Exclusion Model |        |
|--|----------------|-------------------|--------|--------------------------|--------|---------------------------|--------|------------------------|--------|---|--------|
|  |                | n                 | %      | n                        | %      | n                         | %      | n                      | %      | n   | %      |
| Distribution of<br>Ratings   | 1 star         | 141               | 3.1%   | 75                       | 2.5%   | 203                       | 4.5%   | 105                    | 2.3%   | 121   | 4.0%   |
|  | 2 star         | 769               | 16.9%  | 445                      | 14.9%  | 1,074                     | 23.6%  | 675                    | 15.0%  | 666   | 22.2%  |
|  | 3 star         | 2,505             | 55.1%  | 1,196                    | 39.9%  | 2,522                     | 55.5%  | 2,520                  | 55.9%  | 1,340   | 44.8%  |
|  | 4 star         | 1,014             | 22.3%  | 1,128                    | 37.7%  | 677                       | 14.9%  | 1,093                  | 24.2%  | 763   | 25.5%  |
|  | 5 star         | 121               | 2.7%   | 150                      | 5.0%   | 72                        | 1.6%   | 117                    | 2.6%   | 104   | 3.5%   |
|  | Total          | 4,550             | 100.0% | 2,994                    | 100.0% | 4,548                     | 100.0% | 4,510                  | 100.0% | 2,994   | 100.0% |
| Distribution of Stars<br>Gained or Lost  | Lost 2 stars   | -                 | -      | 0                        | 0.0%   | 22                        | 0.5%   | 2                      | 0.0%   | 12  | 0.4%   |
|  | Lost 1 star    | -                 | -      | 0                        | 0.0%   | 1,076                     | 23.7%  | 221                    | 4.9%   | 501   | 16.7%  |
|  | No Change      | -                 | -      | 2,123                    | 70.9%  | 3,198                     | 70.3%  | 3,830                  | 84.9%  | 1,892   | 63.2%  |
|  | Gained 1 star  | -                 | -      | 871                      | 29.1%  | 248                       | 5.5%   | 454                    | 10.1%  | 553   | 18.5%  |
|  | Gained 2 stars | -                 | -      | 0                        | 0.0%   | 4                         | 0.1%   | 3                      | 0.1%   | 35  | 1.2%   |
|  | Gained 3 stars | -                 | -      | 0                        | 0.0%   | 0                         | 0.0%   | 0                      | 0.0%   | 1   | 0.03%  |
|  | Total Movement | -                 | -      | 871                      | 29.1%  | 1,350                     | 29.7%  | 680                    | 15.1%  | 1,102   | 36.8%  |
| Kappa  |                | -                 |        | 0.5743                   |        | 0.5212                    |        | 0.754                  |        | 0.4548  |        |
| Weighted Kappa   |                | -                 |        | 0.6913                   |        | 0.6288                    |        | 0.8087                 |        | 0.5828  |        |

Source: Hospital Industry Data Institute calculations of CMS star ratings data for all hospitals used in the star calculations (i.e., not just those meeting reporting criteria)

Figure 7. Rush University Medical Center- Stars by Size Decile

Stars by Size Decile

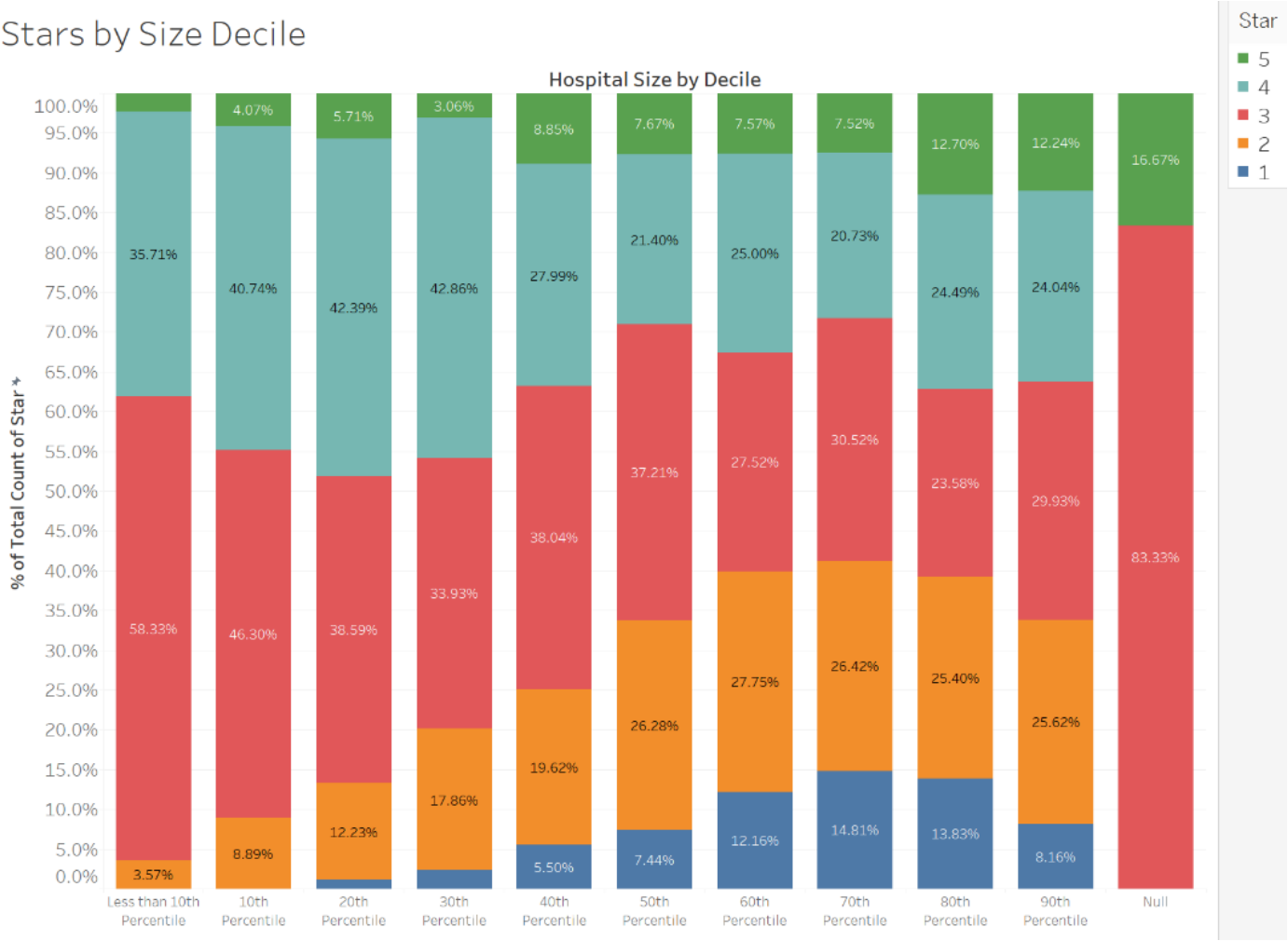


Figure 8. Rush University Medical Center- Stars by Socioeconomic Status

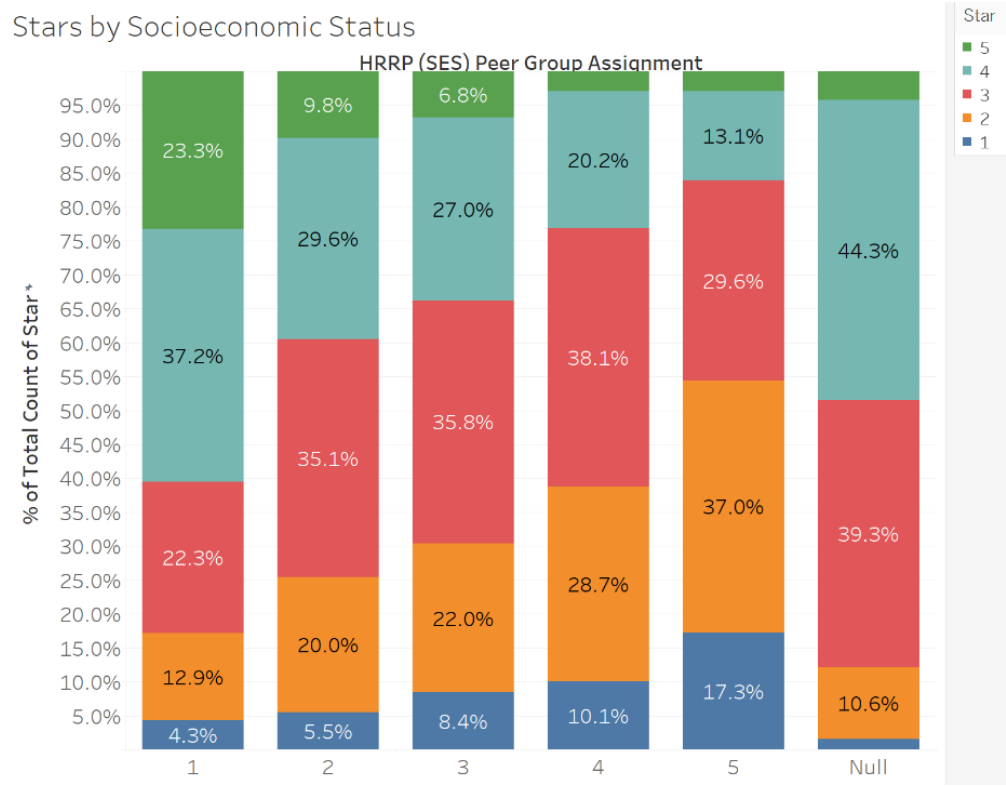


Figure 9. Healthcare Association of New York State- Critical Access Hospitals vs. All Other Providers

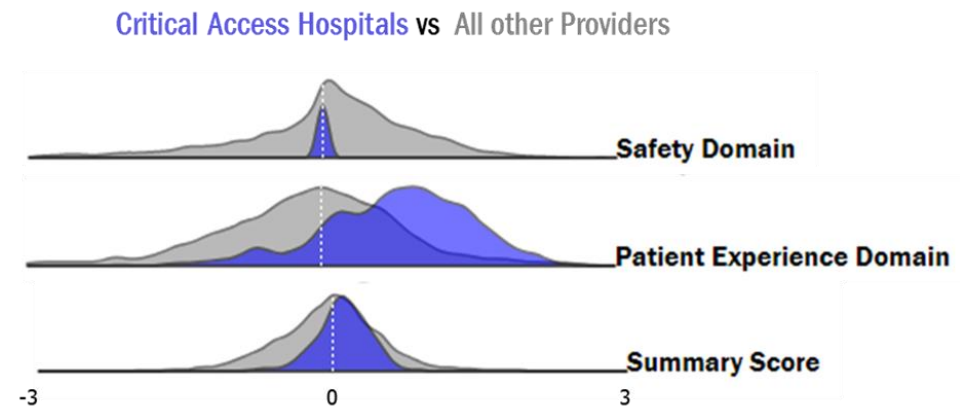


Figure 10. Healthcare Association of New York State- 40% Dual Eligible + Hospitals vs. All Other Providers

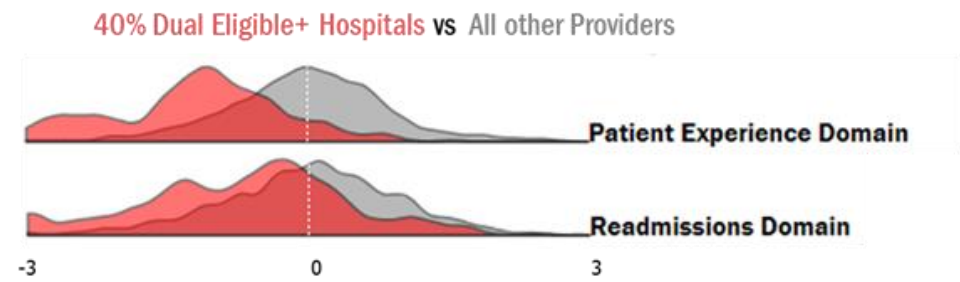


Table 16. Vizient- Percent of Hospitals in FY 2019 CMS Readmission Reduction Program Quintiles versus February 2019 Hospital Star Distribution

| CMS<br>Hospital<br>Star<br>Ratings | CMS HRRP Quintiles |     |     |     |     |     |
|------------------------------------|--------------------|-----|-----|-----|-----|-----|
|                                    |                    | 1   | 2   | 3   | 4   | 5   |
|                                    | 1                  | 8%  | 13% | 19% | 23% | 37% |
|                                    | 2                  | 9%  | 17% | 19% | 25% | 30% |
|                                    | 3                  | 12% | 23% | 23% | 24% | 18% |
|                                    | 4                  | 26% | 25% | 22% | 17% | 10% |
|                                    | 5                  | 47% | 23% | 16% | 7%  | 7%  |

Table 17. Vizient- Percent of Hospitals in the CMS HRRP Quintiles versus Hospital Cohort

|       | CMS Readmission Reduction Program Quintiles |     |     |     |     |
|-------|---|-----|-----|-----|-----|
|       | 1   | 2   | 3   | 4   | 5   |
| AMC   | 10%   | 20% | 22% | 27% | 22% |
| CTMC  | 19%   | 17% | 19% | 22% | 23% |
| Comm  | 23%   | 25% | 22% | 16% | 14% |
| Total | 20%   | 20% | 20% | 20% | 20% |



Figure 11. Vizient- February 2019 CMS Hospital Star Rating Distribution by Hospital Cohort

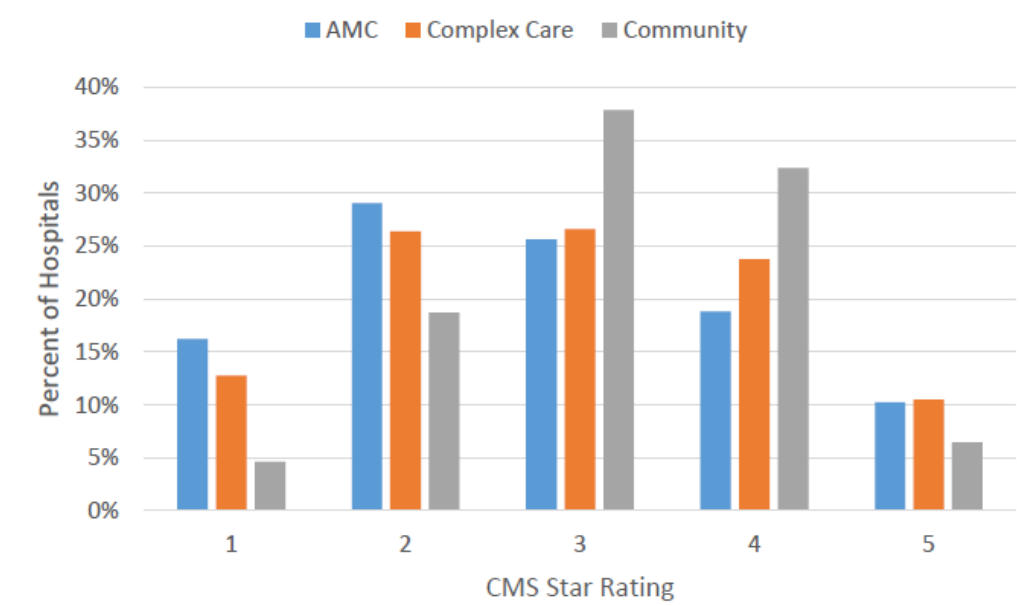


Table 18. Hennepin Healthcare- Data Simplified to Only Three Measures in the Safety Group and Only Ten Hospitals

|               | Hosp A | Hosp B | Hosp C | Hosp D | Hosp E | Hosp F | Hosp G | Hosp H | Hosp I | Hosp J |
|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| PSI-90-Safety | 0.89   | 0.81   | 0.81   | 0.84   | 1.38   | 0.96   | 1.01   | 1.06   | 1.00   | 1.25   |
| COMP-HIP-KNEE | 2.07%  | 2.53%  | 2.28%  | 2.01%  | 2.95%  | 1.80%  | 2.86%  | 3.06%  | 3.05%  | 3.40%  |
| HAI-2         | 0.94   | 1.12   | 0.45   | 0.40   | 0.64   | 1.29   | 0.91   | 0.63   | 0.97   | 1.24   |

Table 19. Hennepin Healthcare

|               | Hosp A | Hosp B | Hosp C | Hosp D | Hosp E | Hosp F | Hosp G | Hosp H | Hosp I | Hosp J |
|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| PSI-90-Safety | 0.63   | 1.08   | 1.06   | 0.90   | -2.09  | 0.21   | -0.06  | -0.31  | 0.00   | -1.41  |
| COMP-HIP-KNEE | 1.04   | 0.14   | 0.62   | 1.15   | -0.67  | 1.57   | -0.52  | -0.89  | -0.87  | -1.57  |
| HAI-2         | -0.26  | -0.88  | 1.36   | 1.54   | 0.72   | -1.43  | -0.18  | 0.77   | -0.36  | -1.26  |

Figure 12. Hennepin Healthcare

$$\begin{pmatrix} 0.63 & 1.08 & 1.06 & 0.90 & -2.09 & 0.21 & -0.06 & -0.31 & 0.00 & -1.41 \\ 1.04 & 0.14 & 0.62 & 1.15 & -0.67 & 1.57 & -0.52 & -0.89 & -0.87 & -1.57 \\ -0.26 & -0.88 & 1.36 & 1.54 & 0.72 & -1.43 & -0.18 & 0.77 & -0.36 & -1.26 \end{pmatrix} =$$
$$\begin{pmatrix} l_1 \\ l_2 \\ l_3 \end{pmatrix} (Q_A \quad Q_B \quad Q_C \quad Q_D \quad Q_E \quad Q_F \quad Q_G \quad Q_H \quad Q_I \quad Q_J)$$

Figure 13. Hennepin Healthcare

$$\begin{pmatrix} 0.91 \\ 0.74 \\ 0.16 \end{pmatrix} (0.68 \quad 0.77 \quad 0.92 \quad 0.93 \quad -1.61 \quad 0.47 \quad -0.17 \quad -0.41 \quad -0.20 \quad -1.38)$$

Table 20. Hennepin Healthcare

|                  | Hosp A | Hosp B | Hosp C | Hosp D | Hosp E | Hosp F | Hosp G | Hosp H | Hosp I | Hosp J |
|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| PSI-90-Safety    | 0.63   | 1.08   | 1.06   | 0.90   | -2.09  | 0.21   | -0.06  | -0.31  | 0.00   | -1.41  |
| COMP-HIP-KNEE    | 1.04   | 0.14   | 0.62   | 1.15   | -0.67  | 1.57   | -0.52  | -0.89  | -0.87  | -1.57  |
| HAI-2            | -0.26  | -0.88  | 1.36   | 1.54   | 0.72   | -1.43  | -0.18  | 0.77   | -0.36  | -1.26  |
| Dual-Eligibility | -1.62  | -0.20  | -0.79  | -0.02  | 1.57   | -1.28  | -0.37  | 0.81   | 1.04   | 0.87   |

Figure 14. Hennepin Healthcare

$$\begin{pmatrix} 0.63 & 1.08 & 1.06 & 0.90 & -2.09 & 0.21 & -0.06 & -0.31 & 0.00 & -1.41 \\ 1.04 & 0.14 & 0.62 & 1.15 & -0.67 & 1.57 & -0.52 & -0.89 & -0.87 & -1.57 \\ -0.26 & -0.88 & 1.36 & 1.54 & 0.72 & -1.43 & -0.18 & 0.77 & -0.36 & -1.26 \\ -1.62 & -0.20 & -0.79 & -0.02 & 1.57 & -1.28 & -0.37 & 0.81 & 1.04 & 0.87 \end{pmatrix} =$$
$$\begin{pmatrix} l_1 & m_1 \\ l_2 & m_2 \\ l_3 & m_3 \\ l_4 & m_4 \end{pmatrix} \begin{pmatrix} P_A & P_B & P_C & P_D & P_E & P_F & P_G & P_H & P_I & P_J \\ Q_A & Q_B & Q_C & Q_D & Q_E & Q_F & Q_G & Q_H & Q_I & Q_J \end{pmatrix}$$

Figure 15. Hennepin Healthcare

$$\begin{pmatrix} 0.77 & 0.14 \\ 0.86 & 0.11 \\ 0.03 & 0.84 \\ -0.97 & 0.24 \end{pmatrix} \begin{pmatrix} 1.44 & 0.10 & 0.98 & 0.40 & -1.37 & 0.99 & 0.24 & -0.65 & -1.00 & -1.13 \\ -0.54 & -0.43 & 0.88 & 1.49 & 0.64 & -1.07 & -0.46 & 0.58 & 0.02 & -1.12 \end{pmatrix}$$

Figure 16. Hennepin Healthcare

$$\begin{pmatrix} 0.71 & 0.32 \\ 0.81 & 0.31 \\ -0.17 & 0.82 \\ -0.997 & 0.00 \end{pmatrix} \begin{pmatrix} 1.52 & 0.20 & 0.74 & 0.04 & -1.48 & 1.22 & 0.34 & -0.77 & -0.97 & -0.83 \\ -0.18 & -0.39 & 1.09 & 1.54 & 0.29 & -0.80 & -0.39 & 0.40 & -0.22 & -1.36 \end{pmatrix}$$

Figure 17. National Organization of State Offices of Rural Health- Overall Rating Comparison-Rural and Urban Hospitals

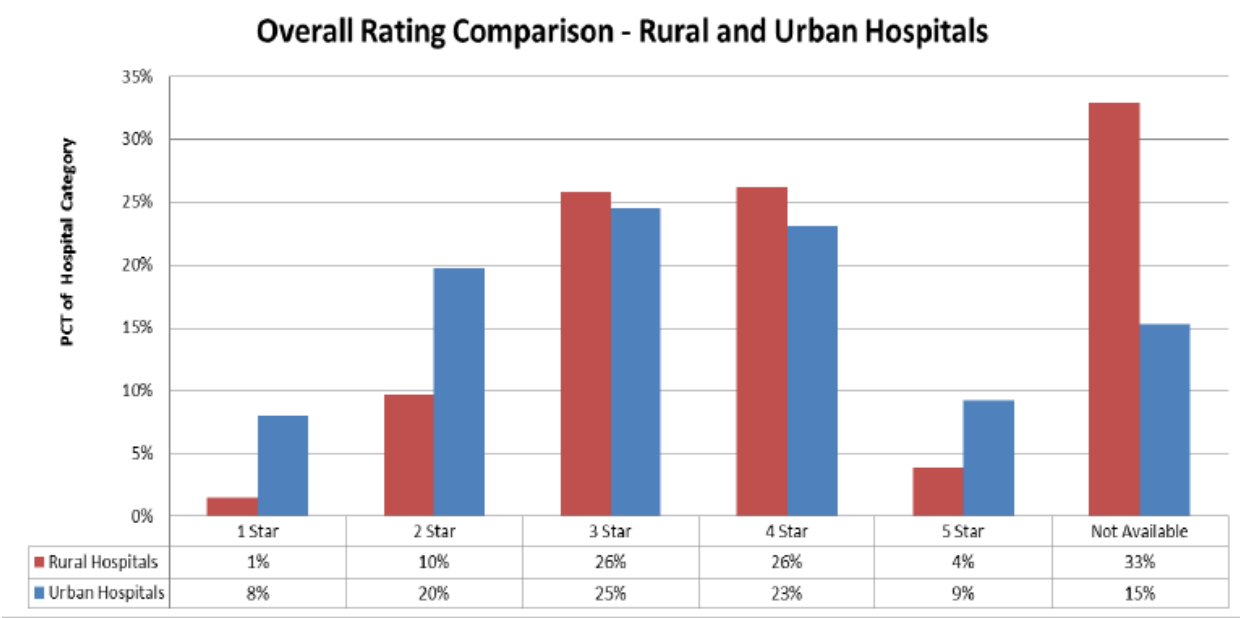


Figure 18. National Organization of State Offices of Rural Health- Rural Hospitals Unscoored Under New Methodology

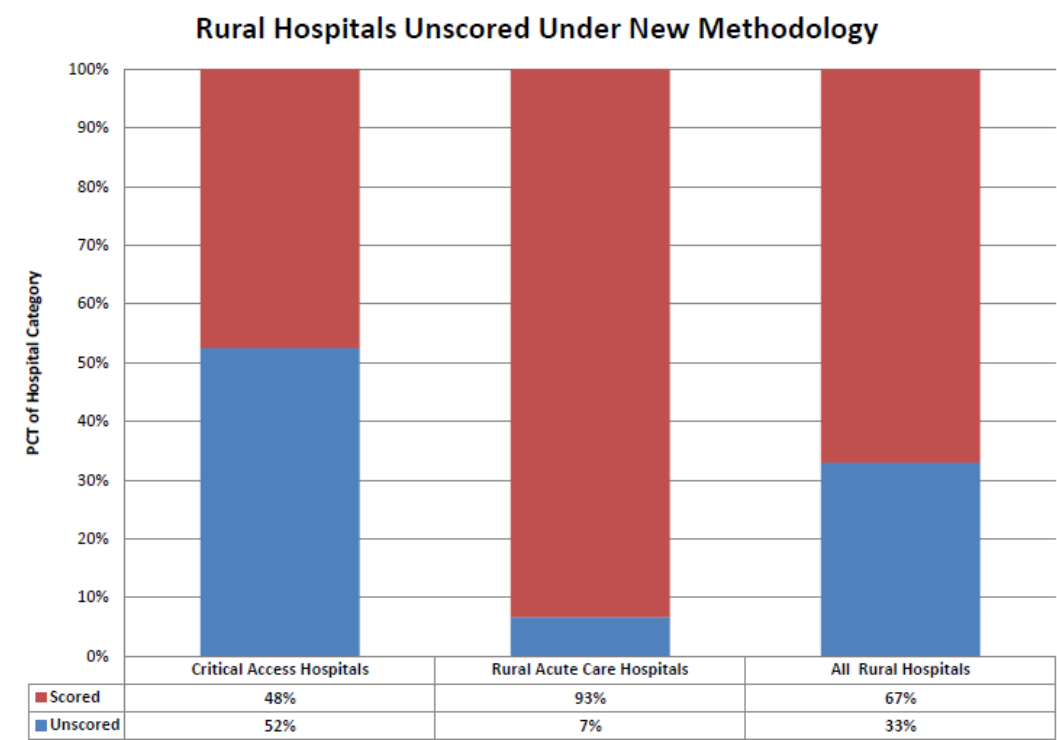


Figure 19. National Organization of State Offices of Rural Health- Number of Measures Reported: Rural Scored Hospitals and Urban Scored Hospitals

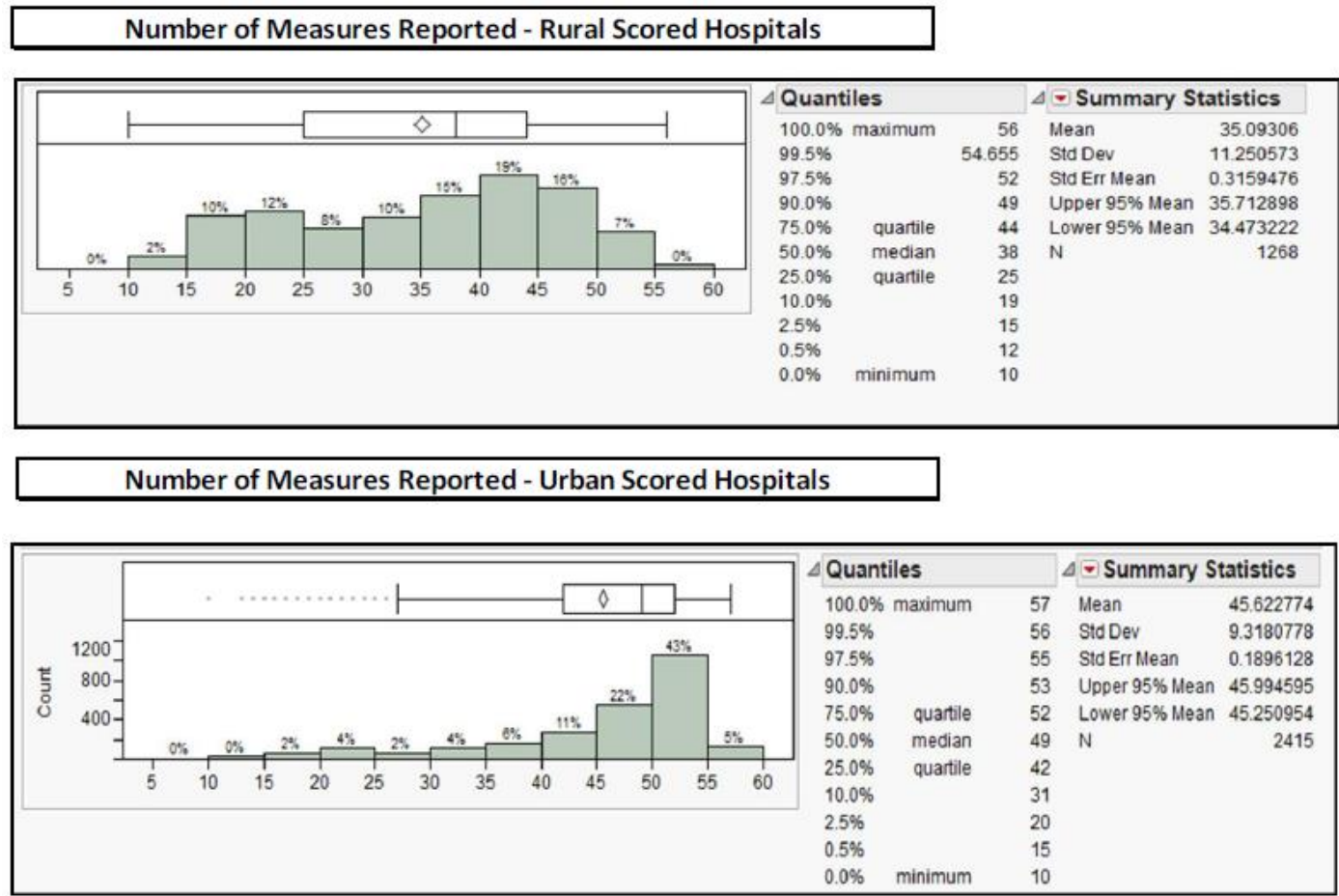


Figure 20. National Organization of State Offices of Rural Health- Domain Excluded in Star Ratings Calculations- All Scored Hospitals

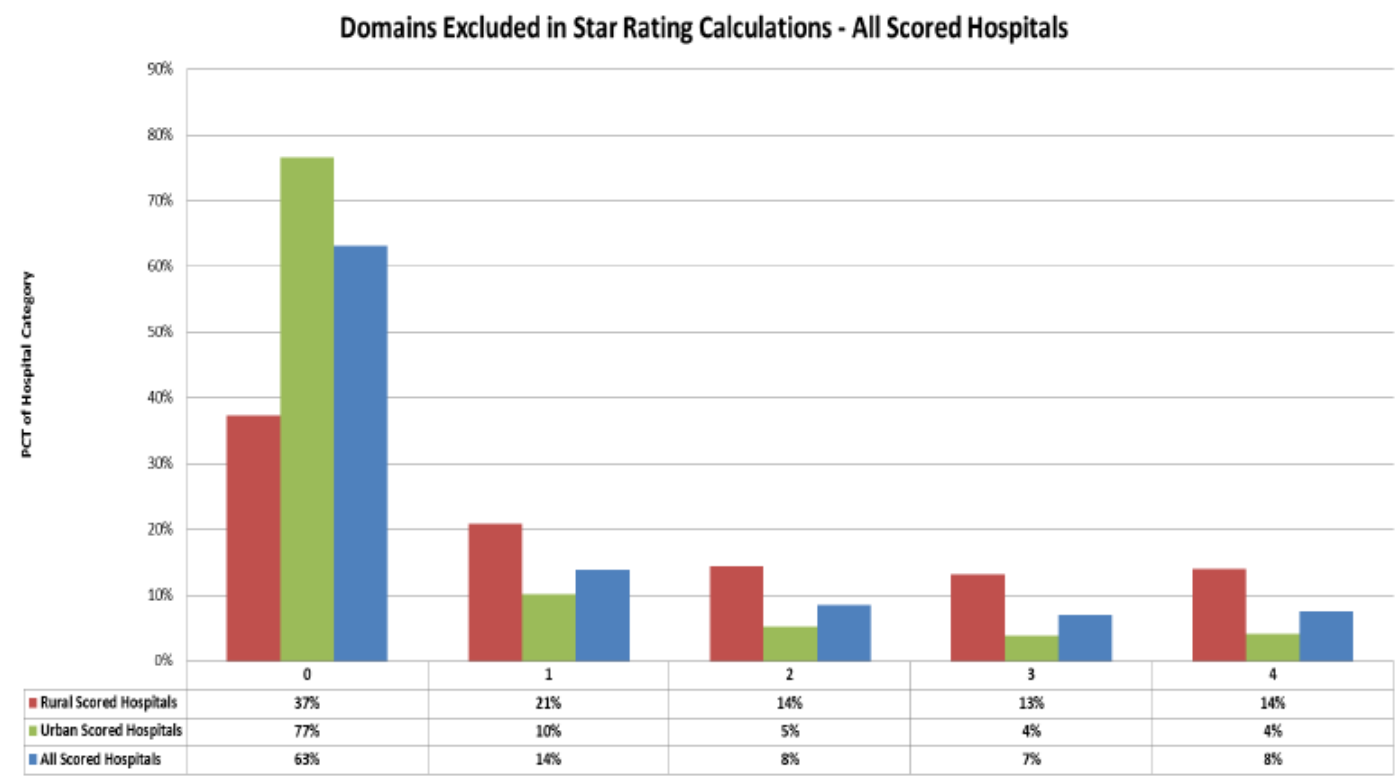


Figure 21. National Organization of State Offices of Rural Health- Overall Rating Comparison: All Hospitals and Rural Hospitals

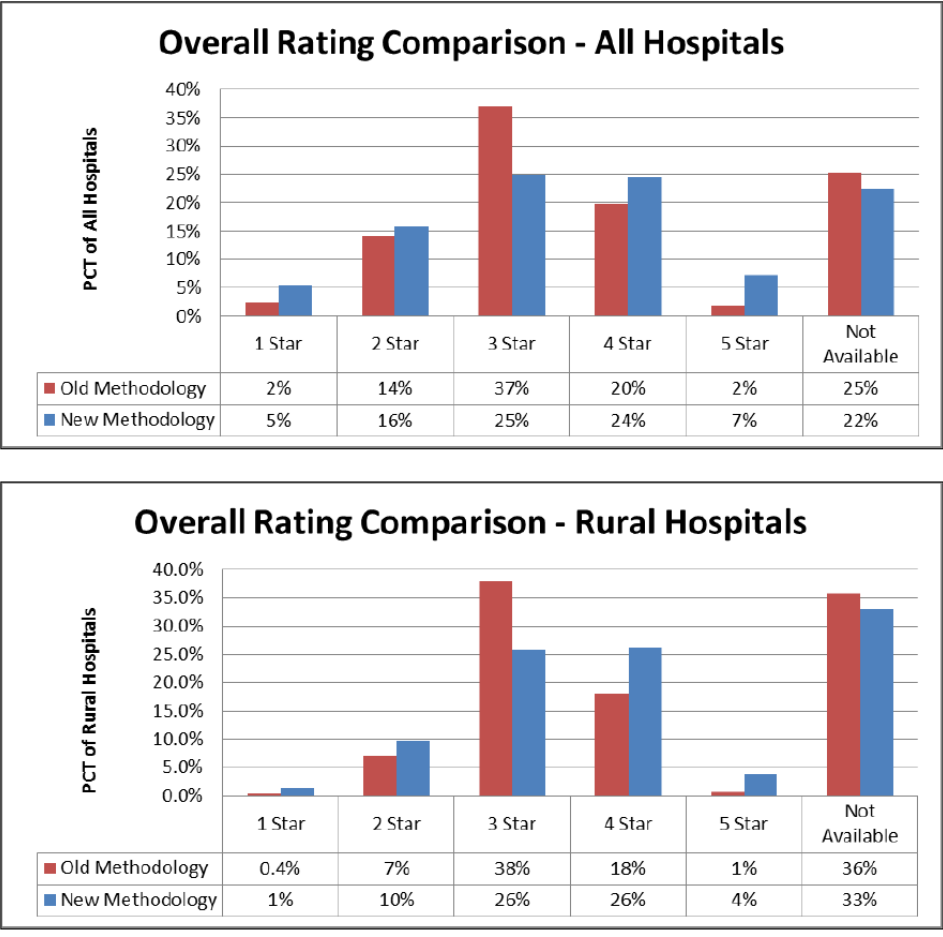


Figure 22. National Organization of State Offices of Rural Health- Safety of Care- Methodology Comparison- Rural/Urban Hospitals

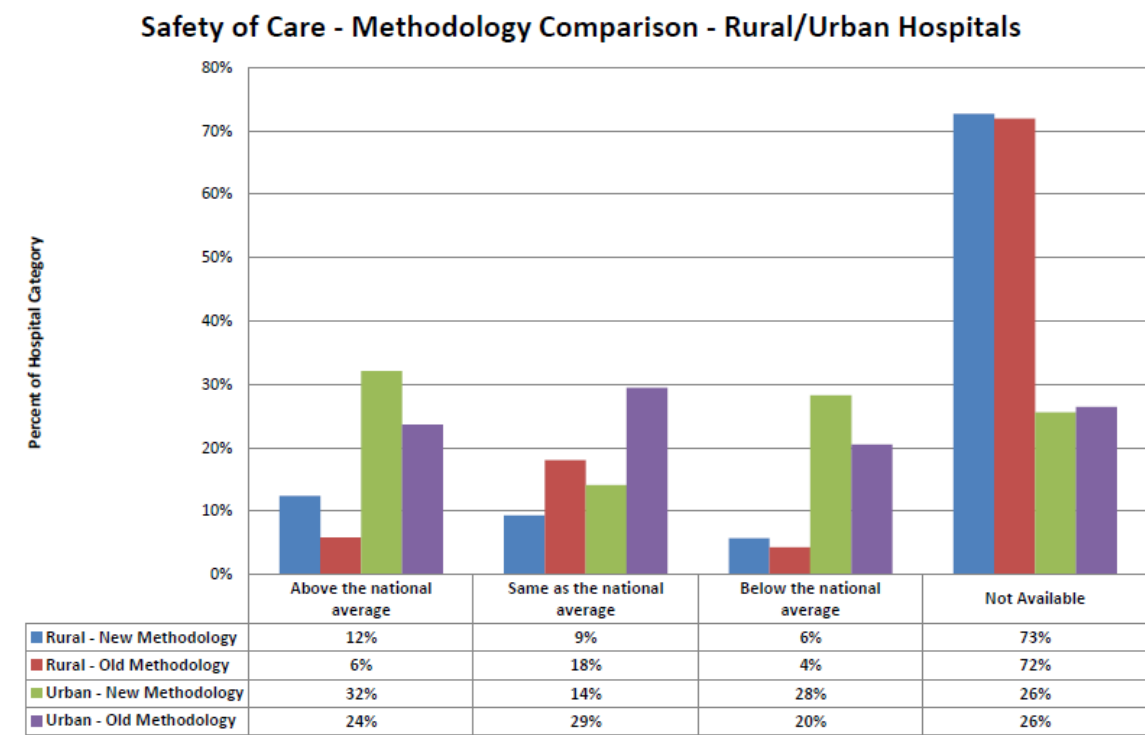




Figure 23. National Organization of State Offices of Rural Health- Readmission- Methodology Comparison- Rural/Urban Hospitals

