

Overall Hospital Quality Star Ratings Public Input Verbatim Report II

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*
3/6/2019	Closed Form Solution	Replace with Closed form solution	Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare	RHyke@stanfordhealthcare.org	Individual	Please refer to the Summary Report
3/27/2019	Closed Form Solution	Second, the AHA cannot support the “closed form” computational method to the LVM without further information about how this approach performs as compared to the current approach. CMS asserts that the closed form approach could produce results that are as accurate as the current “quadrature” approach while taking less time. But the agency does not provide any empirical information to support this assertion. While not included in the public comment proposal, the AHA believes CMS’s ongoing work to improve hospital star ratings should address the three issues below. In fact, we would urge that CMS examine and address these issues before it implements any other changes to the star ratings.	Daniel J. Baker, MD, MBA, Medical Director, Lenox Hill Hospital	djbaker@northwell.edu	Individual	Please refer to the Summary Report
3/27/2019	Closed-Form Solution	MHA appreciates the opportunity to comment on this proposed update. While the details of the proposed approach are very complex, the proposed methods involved are well established, and the rationale presented for making the change is both sound and would offer a variety of benefits to both developers and hospital users seeking to use publicly released SAS packs to recreate CMS Star Ratings. Having previously used these SAS packs to recreate Overall Star Ratings, we recognize the value of algorithmic changes that support faster estimation.	Herb B. Kuhn, President, CEO, Missouri Hospital Association	DLandon@mhnet.com	Hospital Association	Please refer to the Summary Report
3/28/2019	Closed Form Solution	4.6 Computational Update: Closed-form solution of LVM Question for the Public: Should CMS use a “closed-form solution” or make technical changes like this potential solution and consider opportunities for such changes in the future? As previously mentioned, a simplified, explicit approach is needed.	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	DLandon@mhnet.com	Health System	Please refer to the Summary Report

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3/28/2019	Closed Form Solution	Anything that can be run significantly faster than the current methods, which take approximately 40 hours to run, is an improvement. This would reduce barriers for each hospital to run the rankings software on their own.	Dr. 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 Chicago, Illinois; Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine; Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center	Thomas A Webb@rush.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Closed Form Solution	As the “closed-form solution” is described, UPH supports the use of the most efficient method to calculate scores, particularly when it enhances data timeliness. That said, our response is premised on there being negligible operational impact. From this report, we do not know the extent to which coding changes, if any, would need to be incorporated beyond CMS, the associated costs as well as the timeframe to implement. In terms of whether similar technical changes should be considered in the future, we would encourage CMS to explore future improvement but would reserve comment on a specific proposal until operational implications are understood.	Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health; Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health	cathy.simmons@unitypoint.org	Health System	Please refer to the Summary Report
3/29/2019	Closed Form Solution	The largest benefit would be turnaround time to get results out. If that results in data being more recent as time of publication, I’d vote to implement it. The methodology (Appendix C) makes sense.	Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health	kathleencarrothers@gmail.com	Individual	Please refer to the Summary Report
3/29/2019	Closed-Form Solution	We would be supportive if the results from the “closed-form solution” provide the same solutions as the current “quadrature” approach.	Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan	svijan@med.umich.edu	Medical University	Please refer to the Summary Report
3/29/2019	Closed-Form Solution	Additional information is needed in order to evaluate this proposal. Cedars-Sinai urges CMS to research further the usefulness of “closed form” computational method to the LVM through an extensive statistical comparison of the impact of this method on Star Ratings to the current one.	Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center	gail.grant@cshs.org	Hospital	Please refer to the Summary Report
3/29/2019	Closed-form Solution	We support the change to the closed-form solution from the quadrature. Since there is no concern with the calculations and is slightly more precise, the benefit is to have a faster way to calculate and post results is beneficial to hospitals and to the consumers to have more current information available.	Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital	linnea.huinker@northmemorial.com	Hospital	Please refer to the Summary Report

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3/29/2019	Closed-form Solution	<p>4.6 Computational Update: Closed-Form Solution of LVM</p> <p>Should CMS use a “closed-form solution” or make technical changes like this potential solution and consider opportunities for such changes in the future?</p> <ul style="list-style-type: none"> • Yes, we support CMS using a “closed-form solution” to allow the software to run more quickly. This will also allow hospitals to more easily replicate and verify the star ratings. • In addition, we believe CMS must adopt more transparency in the release of star ratings prior to release to the public. All other CMS programs provide preview periods for the data and detail going into the Value Based Purchasing, Hospital Readmissions Reduction Program and Healthcare Associated Conditions Reduction Program. While the Star Rating program is somewhat different, in that it requires the release of all hospitals data, we believe the nation’s hospitals would support this change and it would fulfill the ability of all hospitals to verify star ratings before they are made available to the public. 	<p>Jeremy Boal, MD Chief Clinical Officer Executive Vice President Mount Sinai Health System;</p> <p>Vicki LoPachin, MD Chief Medical Officer Senior Vice President Mount Sinai Health System;</p> <p>G. Troy Tomilonus Vice President, Clinical Decision Support Mount Sinai Health System</p>	troy.tomilonus@mountsinai.org	Hospital	Please refer to the Summary Report
3/29/2019	Closed-form Solution	Although we did not attempt to reproduce or simulate the closed-end solution described in the Public Input Request, we are generally in support of any computational method that produces identical results while optimizing efficiency and usability.	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Closed-form Solution	The Joint Commission encourages CMS to use the most accurate and precise measurements to calculate hospital scores. Replacing the current quadrature methodology with the closed-form solution would be desirable as long as CMS is able to demonstrate that there is little difference between the two methods and makes public the results of the comparison of the two methods.	Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission	PRoss@jointcommission.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Closed-form Solution	Second, MHA cannot support the “closed form” computational method to the LVM without further information about how this approach performs as compared to the current approach. CMS asserts that the closed-form approach could produce results that are as accurate as the current “quadrature” approach while taking less time. But the agency does not provide any empirical information to support this assertion.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Closed-form Solution	Finally, among the near-term options proposed by CMS to improve the accuracy of the Overall Hospital Quality Star Ratings, the agency solicits feedback on the benefits and drawbacks of replacing quadrature with the closed form solution. Ascension believes the closed form solution is the only appropriate solution for the Star Ratings LVM. Quadrature approximation is appropriate for a polynomial of degrees $2n-1$ or less, but it does not ensure an exact approximation for an exponential function. The Star Ratings LVM is an exponential function and the current quadrature approximation does not provide an accurate result. We acknowledge the technical complexities of the LVM methodology and support AHA's request for additional information to support this change.	Peter M. Leibold, Chief Advocacy Officer, Ascension	Danielle.White@ascension.org	Health System	Please refer to the Summary Report
3/29/2019	Closed-form Solution	Closed Form Solution This would not be needed if the LVM were to be abandoned.	Dan Adelman, Professor, University of Chicago Booth School of Business	Dan.Adelman@chicagobooth.edu	Individual	Please refer to the Summary Report
3/29/2019	Closed-form Solution	Our internal technical expert has no qualms about changing the method and recognizes moderate stability improvements by avoiding numerical integration. One potential point of failure, however, is accurately determining the constant of proportionality mentioned in Appendix C, subsection C.4, equation (4). It was unclear from the supporting documentation if this constant is fixed (because it relates to all hospitals) or if it is variable (because each constant is hospital specific). In either case, this constant should be explicitly calculated and not "wiped-away".	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report
3/29/2019	Closed-form Solution	AHPA recommends that CMS find alternatives to the quadrature approach. We find the current approach to be cumbersome to implement.	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report
3/29/2019	Closed-Form Solution	Yes. Methods should be modified when they allow presentation of more timely performance ratings to patients and consumers, particularly when the impact on overall calculations is small. These methodological changes should be documented and made publicly available at least 6 months in advance of application to scoring reports, to allow organizations to understand the changes, estimate the impact, and communicate with patients and other stakeholders about the changes and their impact on performance scores.	Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care	hahncoverk@health.missouri.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Closed-Form Solution	Computational Update: Closed-Form Solution of LVM CMS proposes to replace the quadrature estimation method with the closed-form solution of latent variable modeling. This method ensures quicker, more precise, and more stable results without substantive changes to the model results. GNYHA supports using the closed-form solution of LVM.	Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association	achin@gnyha.org	Hospital Association	Please refer to the Summary Report
2/28/2019	Explicit Approach	<p>4. The use of a Latent Variable Model in the Star ratings introduces variability and inconsistency, making changes in rating hard to interpret.</p> <p>The Latent Variable Model has created confusion and contradictions in interpretation of a safe hospital. CMS runs three separate programs which evaluate hospital safety: Value Based Purchasing (VBP), Hospital Acquired Condition Reduction Program (HACRP), and Overall Rating.</p> <p>These three programs largely use the exact same measures, yet there are inconsistent results on which hospitals are safe or not.</p> <p>[Table 1]</p> <p>For Overall Ratings, the latent variable model continues to peg PSI-90 as the overwhelming favorite for measuring safety.</p> <p>[Table 2]</p> <p>Loading Factors obtained from Hospital Specific Reports</p> <p>[Figure 1]</p> <p>20 Hospital Specific Reports confirm the perfectly linear relationship identified from the loading coefficients between the Safety Domain score and the PSI-90 score. Hospital Acquired Infections are insignificant.</p> <p>This trend was identified in the Dec 2017 release; however, the LVM switched to THA/TKA Complications during the unreleased Jun 2018 version, but back to PSI-90 for Feb 2019.</p> <p>[Figure 2a-2b] show very little to no correlation between HACRP and the VBP Safety domain from the Dec 2017 release. 284 hospitals received a 1% HACRP payment penalty, yet had above average safety scores in Overall Star Rating.</p> <p>[Figure 2a-2b]</p> <p>Data obtained from data.medicare.gov</p> <ul style="list-style-type: none"> • Inconsistency of safety measurement creates confusion between results of various CMS programs. Patients and hospitals don't know what to believe as safe. 	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	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report

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3/6/2019	Explicit Approach	<p>Thank you for the opportunity to comment on the STAR ratings. Orlando Health is continuously striving to make improvement in patient outcomes and in doing so to ensure consistent approaches in assessing our improvements. Reporting data is a complex process and, as I am sure you are aware, requires extensive resources and technology. As you approach the modifications in the methodology please keep these points in mind and consider them when adopting new approaches.</p> <p>1. Predetermined weighting of metrics with minimal differential weighting</p>	Patricia D. Boyette, MSHS, BSN, NE-BC Director, Operational Performance Improvement Corporate Quality, Orlando Health	Patricia.Boyette@orlandohealth.com	Health System	Please refer to the Summary Report
3/11/2019	Explicit Approach	An explicit or simplified approach to calculate overall star rating would be beneficial for hospitals to understand how to improve star rating. The current statistical methodology is too advanced for hospitals without advanced analytics teams to recreate and validate, much less be able to use the information to improve care and ratings.	Rhonda Unruh, MHA, RN, CIC, Vice President of Quality, Guadalupe Regional Medical Center	runruh@grmedcenter.com	Individual	Please refer to the Summary Report
3/13/2019	Explicit Approach	<p>Asante would like to provide comment on the Overall Hospital Quality Star Rating provided on the Hospital Compare website.</p> <p>Asante would support moving away from the latent variable model to an explicit model to improve transparency and accuracy of the individual measure's contribution to performance. It's recognized there may be inherent relationships between measures; however, there are also distinct drives for each measure, thus why each is tracked and benchmarked by CMS.</p> <p>The purpose and intent of the star rating system is to summarize information in a way that is useful and easy to interpret for patients and consumers. The complexity of the current methodology hinders this objective as it obscures true (explicit) performance and replaces it with inferred performance.</p>	Jamie Grebosky, MD, Asante Chief Medical and Quality Officer, Vice President, Medical Affairs AACH	JAMES.GreboskyMD@asante.org	Health System	Please refer to the Summary Report

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3/14/2019	Explicit Approach	<p>What are the advantages and disadvantages of a more explicit approach to calculating Overall Hospital Quality Star Ratings?</p> <p>HFHS strongly favors an explicit approach to calculating the Star Ratings, for some reasons that have already been discussed above. We would favor an explicit approach to the weighting of measures within groups, just as the relative weights for the groups themselves is explicit now. We would also favor the setting of explicit cutpoints on measures or measure groups to establish eventual global Star Rating scores rather than the current k-means clustering approach that pits all hospitals against each other in a "tournament model." We would favor a system in which the criteria for achieving each Star level was set in advance, kept in place for some period of time, with the resulting distribution of ratings allowed to shift upwards as hospitals in general improve their performance.</p> <p>We can't think of any clear disadvantage to an explicit approach, although we acknowledge that statistical purists can find such disadvantages, if they start with the design assumption that the Star Rating system must be a "tournament</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report

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3/14/2019	Explicit Approach	<p>model" format with a finite number of hospitals in each of five groups as a result of highly technical scoring and grouping and weighting methods along the way. For example, on page 39, it is noted that: "An advantage of LVM that would be lost is that it allows the data to empirically estimate loadings based on the correlations between measures for each refresh." It seems unlikely to us that this rationale would be compelling to any hospital administrator or clinician, if the alternative is to have a set of clear, straightforward, explicit values for all relevant weights and cutpoints so as to create clear targets for quality improvement.</p> <ul style="list-style-type: none"> Is the explicit approach a worthwhile change in approach and direction to consider further? <p>Yes, definitely.</p> <ul style="list-style-type: none"> How could such an approach be best operationalized or sustained? <p>HFHS has discussed this issue in earlier responses and don't want to be repetitive here, but briefly, CMS could use either an objective, empirical basis like "QALYs lost", or formal qualitative methods like focus groups or a Delphi process or crowdsourcing to assign clinical significance weights to measures in a category. CMS could then examine the existing distributions of measures to identify cutpoints for groupings like quintiles. The two things could be combined in a relatively simple scoring rule that CMS and any other interested party could calculate in Excel. At some defined intervals (five years for the measure cutpoints, 10 years for the weights?), the explicit parameters could be updated. In between, hospitals would have a FAR easier job focusing and sustaining their QI efforts because they would be aiming for fixed targets rather than mysterious moving targets that they cannot know or understand. Consumers would find the system easier to use as well, as it would be based on relatively simple mathematical ideas and methods.</p> <ul style="list-style-type: none"> 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? 	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report

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3/14/2019	Explicit Approach	<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. For example, patients may judge a MRSA infection to be more important than a pressure ulcer, or a formal analysis of QALYs lost with either one may indicate that one is clearly more significant than the other. Either subjective importance weights obtained through formal methods, or weights obtained by review of literature on QALY losses could be used to establish measure weights. Measures that are not markedly different from each other (i.e., all very important) can be given equal weight.</p> <ul style="list-style-type: none"> 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>HFHS encourages CMS to apply a better, simple, more rational weighting system to any and all measure groups for which the change can be made. It is not crucial that it be "all or none", particularly if the inability to apply an improvement to all groups would prevent the improvement to some groups from being made.</p> <ul style="list-style-type: none"> Are there other approaches that CMS should consider? <p>As noted just above, HFHS strongly encourages CMS to adopt a different set of basic concepts to assigning weights to measures in each group - moving away from purely statistical methods for assigning weights and moving toward simple, explicit, easy-to-understand weights based primarily on the relative clinical significance of measures in a group.</p> <p>Any complex statistical weighting system should carry a heavy burden of proof to demonstrate that the resulting scores are superior in some tangible way to those that would be produced by a much simpler explicit weighing system, including even something as simple as assigning equal weights to all measures in a group. Theoretical superiority is not sufficient - the burden of proof is to show that the complex weighting system produces overall rankings that are better, more accurate, more informative, or in some other way clearly superior</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report

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3/14/2019	Explicit Approach	as judged by both patients and providers. The current methods are incredibly opaque, even to sophisticated staff of hospitals who have degrees in math or statistics. It is simply not possible, given the current methodology, or even some of the alternatives suggested here, to get to a point where a typical hospital administrator or clinician ,or QI lead, could tell how much improvement in a given measure or set of measures would be necessary to move to a higher Star Rating. The goal for CMS in improving the Star Rating system should be to move to a method that can be used in Excel rather than in SAS. That is, the weights, loadings, and all other rules of combination should be expressed in simple arithmetic terms with explicit, pre-set values whenever possible.	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report
3/15/2019	Explicit Approach	-I don't particularly care for the latent variable model. The weighting should be standardized.	Kathy J. Nunemacher MSN, RN, CPN, CPHQ St. Luke's University Health Network Network Director Clinical Quality Data Governance and Reporting	Kathy.Nunemacher@sluhn.org	Individual	Please refer to the Summary Report

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3/21/2019	Explicit Approach	<ul style="list-style-type: none"> What are the advantages and disadvantage of a more explicit approach to calculating Overall Hospital Quality Star Ratings? <p>Advantages are that it would be easier to explain to consumers and hospitals both in terms of what the star rating represents and how it is calculated. Hospitals could more easily understand changes, identify measures contributing to change, and target improvement. A disadvantage is that we would be missing the extra component that latent variable modeling tries to measure.</p> <ul style="list-style-type: none"> Is the explicit approach a worthwhile change in approach and direction to consider further? <p>Yes. The same measures are used in hospital pay for performance programs with explicit methods to calculate scores.</p> <ul style="list-style-type: none"> How could such an approach be best operationalized or sustained? <p>Continued involvement of stakeholders is important. Convening workgroups and further analyzing data to best understand how ratings are affected would need to happen. Perhaps pre-specified ratings would be best with the ability of the consumer to see each measures score for further understanding.</p>	Jennifer Lamprecht, MS, RN, CNL, CPHQ Director Quality Strategy Sanford Health	Jennifer.Lamprecht@SanfordHealth.org	Health System	Please refer to the Summary Report
3/19/2019	Explicit Approach	Abandoning the latent variable model in the composite rating for the star rating would address its lack of consistency.	Autumnjoy Leonard, Clinical Quality Compliance Auditor, Summit Healthcare Regional Medical Center	aleonard@summithealthcare.net	Hospital	Please refer to the Summary Report
3/21/2019	Explicit Approach	Based on the analysis that was conducted by Vizient, OHSU supports the recommendation that CMS switches as soon as possible from a LVM approach to an Explicit Measure approach. Per the Vizient analysis, this would actually bring CMS closer to its intended goal of objectivity in assigning measure weights. In addition, it would align CMS's Star Rating approach to its Pay-for-Performance approach, creating a consistent and simpler hospital evaluation program for patients and providers.	Elana Zuber, MBA, Quality Management System Program Manager, Oregon Health and Science University	matere@ohsu.edu	Medical University	Please refer to the Summary Report

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3/21/2019	Explicit Approach	If I understand your Latent methodology, it seems to lead to shifting variables being used on a yearly basis--a lack of consistency in what is being measured. I think it makes more sense to consistently align more closely with the VBP, Readmission Reduction, HAC Reduction and other variables measured by CMS, and then to use these as a consistent basis for developing an overall Star rating. This gives hospitals an opportunity to focus on improvements and in being rewarded for those improvements.	David Raymond, MPH, President, Clinical Financial Management Associates, LLC	draymond@clinicalfinancial.com	Individual	Please refer to the Summary Report
3/22/2019	Explicit Approach	We are very supportive of CMS choosing an explicit approach to weighting metrics in the seven domains. We appreciate the transparency and reliability of an explicit model.	Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University	bruce.meyer@jefferson.edu	Health System	Please refer to the Summary Report
3/25/2019	Explicit Approach	For the future, CMS should consider implementing an explicit approach to calculating Overall Hospital Star Ratings	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/25/2019	Explicit Approach	By using the LVM, CMS is allowing the “system” or “math formula” to determine the importance of individual quality metrics. We believe that CMS, through its usual processes of stakeholder and TEP input, should determine the importance of individual quality metrics and the weight they should have in calculating the Overall Hospital Star Rating. Predetermined weightings would better allow BHS to focus its limited resources on key quality improvement initiatives.	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report

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3/27/2019	Explicit Approach	A “line of sight” from star ratings to performance on underlying measures. Because star ratings are publicly reported, hospitals should be able to see how any positive or negative changes in underlying measure performance are reflected in their star ratings in a transparent and predictable fashion. Since their inception, 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. heterogeneous measures included in star ratings. Yet, as we 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.	Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association	ademehin@aha.org	Hospital Association	Please refer to the Summary Report

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3/27/2019	Explicit Approach	<p>CMS has indicated in the past that it views star ratings as 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. For these reasons, 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.</p> <p>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. But, 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.</p>	Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association	ademehin@aha.org	Hospital Association	Please refer to the Summary Report

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3/27/2019	Explicit Approach	MHA believes the potential longer-term change outlined in this section would offer significant benefits to providers and consumers in terms of transparency and understandability, and perceive limited downside from the use of explicitly defined weights in place of those that are derived by an algorithm that few people understand. While we recognize that a switch to explicit weights would involve some degree of “arbitrariness” inherent in evaluating a gestalt of stakeholder input over time, we also note that a switch to explicit weights would obviate many of the methodologic concerns raised to date by providers, including those that gave rise to potential updates outlined in sections 4.1, 4.2 and 4.3. We further note that periodic confirmatory factor analysis methods could and likely should still serve as a valuable starting point for explicitly defined measure group weights, but that this step should necessarily be followed with some refinement based on stakeholder input, and delivering an explicit calculation approach would support greater understanding and more meaningful provider response.	Herb B. Kuhn, President, CEO, Missouri Hospital Association	DLandon@mhanet.com	Hospital Association	Please refer to the Summary Report
3/27/2019	Explicit Approach	We believe the CMS latent variable model approach and measure loading coefficients to be subjective, not objective and that many of the proposed CMS recommendations could be addressed by using a simpler, more consistent, explicit measure weighting approach. We recommend that CMS explore using a weighting approach that is consistent with the other CMS payment programs such as Value Based Purchasing. This would align the programs performance and make more sense to the public.	Angela A. Shippy, MD, FACP, FHM SVP & Chief Quality Officer Memorial Hermann Health System	Angela.Shippy@memorialhermann.org	Health System	Please refer to the Summary Report

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3/27/2019	Explicit Approach	<p>Rethink the latent variable modeling approach</p> <p>CCH urges CMS's to evaluate alternatives to weighting measures in order to increase the latent variable model's reproducibility and reliability over different measurement periods. A first step may include incorporating individual hospitals' older performance ratings with their current performance in an attempt to stabilize Hospital Rating Shifts over time. CMS could also choose to publish the full details of its model to help hospitals anticipate new ratings.</p> <p>CCH appreciates CMS' efforts to improve the face validity of its model - even if by a marginal amount. However, the latent variable model does not appear to be the best approach for the data and therefore, no matter the adjustments made, inconsistency and bias modeling results remain. For instance, certain hospitals are still being penalized by the model's tendency to weight certain measures with statistically significant negative loading coefficients for providing better care. Despite the different measure precision enhancement approaches chosen by CMS, latent variable modeling continues to produce inconsistent, unreliable results. CMS's Measure Regrouping Recommendations do not fully address our concerns with latent variable modeling. CCH continues to urge CMS to create a more consistent, reliable approach that aligns with acknowledging better care.</p> <p>A more explicit measure approach.</p> <p>Despite CMS' claims that latent variable modeling is objective, CCH believes the latent variable model approach and measure loading coefficients to be subjective and that many of the proposed CMS recommendations should be addressed by using a more explicit measure weighting approach. We understand that developing this new modeling approach would take time, which is why we urge CMS to take into consideration the suggestions above. In the long term, however, a move toward a more explicit weighting approach would allow hospitals to understand exactly how different measures are taken into account and weighted for their final rating - hospitals could thus choose to adapt their practices accordingly.</p>	John Jay Shannon, CEO, Cook County Health	joshua.mark@cookcountyhhs.org	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*
3/28/2019	Explicit Approach	Explicit Approach: The AAMC supports additional work around the development of an explicit approach to replace the Latent Variable Modeling. The Potential of a Template Matching Model as an Alternative Approach The current method of measuring hospital outcomes on Hospital Compare primarily focuses on an indirect standardization, where a hospital's own case mix is used for comparing performance. This approach compares hospitals that maintain important differences in patient populations served (both in complexity and in social risk factors).	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report
3/28/2019	Explicit Approach	An alternative approach could combine the benefits of indirect standardization with the appropriateness of direct standardization, which seeks to compare hospitals relative to an external reference population. This may be more meaningful for patients in that such a method would be more reliable for defining how well the hospital has done with other patients who have the condition for which they are seeking care. ^{7, 8} A mixed approach, known as a “hospital-specific template matching method”, recently developed by researchers, seeks “to better implement indirect standardization analyses for improving a hospital’s quality of care specifically tailored to the index hospital’s most relevant patients – the patients they see.” ⁹ Under this approach, they have found that the method “combines the fairness of comparison from direct standardization with the specific institutional relevance of indirect standardization.” Considering that the Hospital Compare Overall Quality Star Rating is meant to assist patients and consumers choose hospitals based upon quality information and help guide hospitals in their quality improvement activities, the template matching model may be a valid alternative worthy of full consideration. The AAMC urges CMS to explore the template matching, or other approaches that directly compare patient groups, as a possible alternative model to use for rating hospitals. Potential Long-Term Methodology Changes Explicit Approach CMS is considering replacing the latent variable modeling (LVM) with a less complex or more explicit approach. The LVM was chosen in part to reduce	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report

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3/28/2019	Explicit Approach	<p>arbitrariness, but as a disadvantage the LVM introduces inherent uncertainty into the ratings at hospitals because the measure loadings are unknown until data is refreshed and may change over time. This leads to little transparency or predictable advance notice for hospitals in how changes in individual measure scores may impact hospital Star Ratings.</p> <p>CMS describes different ways it could implement an explicit approach. One discussed in the public input request is to keep the current methodology except that instead of the LVM to determine measure loadings, CMS would assign weights to each measure within a group. While this would provide greater transparency and predictability to hospitals, it would require broad stakeholder agreement on which measures to weight more heavily, or whether to weight all measures equally. Furthermore, CMS believes such consensus might be difficult to achieve, especially over time as measures may change. The LVM approach, while not transparent or predictable, may be more feasible to maintain over time as it responds to the data based on the correlations between measures each refresh to calculate measure loadings. In response to this public input request, we anticipate others will propose specific, technical alternative approaches to the LVM. The AAMC asks that CMS share these proposals, and produce a comparative analysis to which stakeholders can respond to.</p> <p>The AAMC agrees that an explicit approach is likely to be easier to understand for hospitals and patients alike, introduce predictability and transparency to the ratings, and allow for a greater balance and consistency of measure weights. We acknowledge that gaining consensus on measure contribution weights would likely be difficult, but that process may ultimately result in greater stakeholder “buy-in” on the Overall Hospital Quality Star Ratings. One way to operationalize such consensus is to convene a single, inclusive advisory group, rather than separate work groups separating stakeholders, whose deliberations are open to the public and whose recommendations to CMS are subject to public comment.</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report

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3/28/2019	Explicit Approach	<p>Such a group could be formed initially to provide feedback on the development of an explicit approach and retained for annual reviews for maintenance of the approach. Overall, the AAMC supports additional work around the development of an explicit approach for CMS to consider further. In particular, the AAMC urges CMS to consider template matching, and other models that allow for a direct comparison of hospitals, for additional exploration (as described earlier in these comments).</p> <p>7 See Silber, JH et al. A hospital-specific template for benchmarking its cost and quality. Health Services Research. October 2014. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/25201167</p> <p>8 See also Silber JH et al., Comparison of the Value of Nursing Work Environments in Hospitals Across Different Levels of Patient Risk. JAMA Surgery. June 2016. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/26791112.</p> <p>9 See Silber et al., A hospital-specific template for benchmarking its cost and quality, 1477</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report
3/28/2019	Explicit Approach	With respect to other methodological adjustments, we support simplifications that would promote enhanced patient and hospital understanding. In this regard, we favor an explicit approach that will be more transparent to both patients and providers.	Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital Henry Pitt, MD, Chief Quality Officer, Temple University Health System	henry.pitt@tuhs.temple.edu	Health System	Please refer to the Summary Report
3/28/2019	Explicit Approach	However, the methodology is becoming more complex and harder to explain the hospital leaders. The better solution is not to fix or adapt the LVM model, but to move toward an explicit, reproducible model that can be easily explained, replicated, and applied to performance improvement efforts for health systems.	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report

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3/28/2019	Explicit Approach	<p>What are the advantages and disadvantages of a more explicit approach to calculating Overall Hospital Quality Star Ratings? The advantages of a more explicit approach are 1) simplicity of the model and the ability for hospitals to replicate/predict future scores. A more explicit approach also provides a more direct line of sight to potential opportunities for actual performance improvement. The current approach has zero connectivity to performance improvement, patient safety, or clinical outcomes.</p> <p>Is the explicit approach a worthwhile change in approach and direction to consider further? Yes, we understand the difficulty of determining the weights; however, hospital leaders need to be able to understand and explain any rating that is used and displayed to the public. When people see a star rating, they expect it to behave like any other star rating (Yelp, Google, Travelocity, etc...). If the ranked business (in this case a hospital) performs well or to a set standard, 100% of those ranked should all be able to achieve a 5 star ranking if they perform to the highest standards. In the current model, which is designed for a fixed bell curve of performance, this is mathematically impossible. The average consumer has no concept of this when they see a star ranking come out from CMS. If CMS is to stay with a star ranking system, it is imperative that they simplify their approach,</p>	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report
3/28/2019	Explicit Approach	<p>emulating star ranking systems that consumers are accustomed to seeing so that there is a direct connection of the ranking to actual performance.</p> <p>How could such an approach be best operationalized or sustained? CMS will need to determine, consistent, clinically appropriate standards that are replicable and achievable. Using more real time data from EHRs as opposed to retrospective claims based data may help to achieve this goal.</p>	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report

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3/28/2019	Explicit Approach	These consideration can be avoided by moving away from the Latent Variable Model to a more understandable method such as the explicit approach.	Dr. 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 Chicago, Illinois Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report

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3/28/2019	Explicit Approach	<p>We recommend the CMS Overall Rating program should move away from black box statistics to the explicit approach, where measures have known weightings. This would make it significantly easier for hospitals and consumers to interpret drivers of performance. Methods for combining multiple quality measures should be consistent across the CMS programs including Overall Rating, VBP, HACRP, and HRRP.</p> <p>To create and maintain the weights, an expert panel should be convened with public input to set measure weights. (see comment above #1 in prior section).</p>	<p>Dr. 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 Chicago, Illinois Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center</p>	<p>Thomas.A.Webb@rush.edu</p>	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>5. Explicit Approach to Calculating Overall Hospital Quality Star Ratings Advocate Aurora supports the explicit approach to calculating Overall Hospital Quality Star Ratings as we feel this approach would make it easier for consumers to understand. We recommend CMS apply fixed weights to measures within a group but apply an adjustment factor to compute the final score based on a hospital's unique risk characteristics.</p>	<p>Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health</p>	<p>Shauna.Mccarthy@advocatehealth.com</p>	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>2. <u>Incorporating measure precision</u>. According to multiple experts who have studied the LVM, there are strong recommendations to discontinue this methodology of grouping and weighting measures. LVM does not allow hospitals to know, until after the fact, what measures carry the most weight and whether improvement strategies based on the published star rating will, in fact, have a positive impact on future star ratings. LVM is a statistical approach that gives more emphasis on some measures over others based on variation in performance and volume, which is then used to compute a statistical correlation between the measures within each grouping. The statistical model then establishes a "weight" for each measure within the group. This is not a transparent process. It is impossible for an individual to re-create the model independent of the performance of all hospitals submitting measure data.</p> <p>Vizient analyzed the December 2017 publicly available CMS Hospital Star Rating data and identified significant indications in the Agency's LVM approach of modeling selection bias producing unreliable loading coefficients and potentially misleading results.¹ As a result of their assessment, Vizient believes the LVM approach and measure loading coefficients to be subjective, not objective, and that many of the proposed CMS recommendations would be addressed by using a more explicit measure weighting approach. We would agree with the Vizient assessment and recommendation to move to a pre-defined measure weighting system that would be transparent and would guide hospitals in determining effective future improvement strategies.</p>	Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic	deylingc@ccf.org	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>Our comments regarding more long-term potential changes include:</p> <p>1. Using an explicit approach to calculate overall hospital quality star ratings. We reiterate our recommendation to move to an explicit approach to determine measure weighting that remains stable from one refresh to the next refresh, instead of the current LVM methodology,</p>	Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic	deylingc@ccf.org	Medical University	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>In reviewing the future longer-term considerations that were outlined for the CMS Overall Quality Hospital Star ratings, we would like to offer the following comments:</p> <p>Explicit Approach to Calculating Ratings: We fully support a move away from using a statistical model (latent variable modeling) for determining a hospital's measure group score to assigning fixed weights for each measure in a measure group. An explicit approach is fully transparent, predictable for hospitals, and assesses all hospitals in the same manner. Relative weights for the individual measures could be set using criteria such as: the strength of evidence, the impact on patients (both numbers of patients and degree of harm), and/or hospital opportunity for improvement.</p>	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>UPH agrees that the current Star Ratings methodology is overly complex and supports efforts to simplify methodology for consumers to increase its intuitive nature and understanding by users. An advantage to an explicit approach is that it is more transparent and closely correlated to better outcomes. However, even a more straightforward approach will require consumer education regarding meaning and use. Again, this raises the tension between a public facing tool and CMS value-based initiatives aimed at provider standards, and it should be noted that any transition to an explicit approach would further complicate the ability to make comparisons between Hospital Compare scores and CMS quality programs.</p>	<p>Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health</p> <p>Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health</p>	cathy.simmons@unitypoint.org	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>Understandability and “clear targets/criteria would be benefit. Statistically, LVM is better and agree deciding upon weights would be challenging with out clear cut contribution/attribution of every measure to harm/mortality, etc.</p> <p>Don’t recommend explicit approach; artificially weighing measures, and vulnerable to “lobbying”.</p> <p>If it moved forward, one idea would be to have technical panel of all stakeholders (3-year term, rotating out 1/3 each year) to decide weights.</p>	Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health	kathleencarrothers@gmail.com	Individual	Please refer to the Summary Report

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3/29/2019	Explicit Approach	LVHN encourages the replacement of the latent variable modeling (LVM) currently used to calculate the star rating and recommends creating a defined set of measure weights similar to CMS Value Based Purchasing (VBP) and Hospital Acquired Condition (HAC) programs. LVM does not maintain consistency, precision or accuracy between time periods thus not accurately reflecting the quality of care provided. LVM disproportionately weights certain variables. The imbalance of variable weighting and measure loading coefficients leads to subjective results, which are not beneficial or easily understood by the public plus are not relevant to outcome measures such as mortality. It is imperative that CMS contract with independent outside experts to review the methodology and verify its accuracy before public implementation.	Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report
3/29/2019	Explicit Approach	Explicit approach to calculating overall hospital quality star ratings: CMS is considering replacing the latent variable modeling (LVM) with a less complex or more explicit approach. The LVM was chosen in part to reduce arbitrariness, but as a disadvantage the LVM introduces inherent uncertainty into the ratings at hospitals because the measure loadings are unknown until data is refreshed and may change over time. This leads to little transparency or predictable advance notice for hospitals in how changes in individual measure scores may impact hospital Star Ratings. LVHN supports additional work around the development of an explicit approach to replace the Latent Variable Modeling.	Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report
3/29/2019	Explicit Approach	Explicit Approach to Calculating Overall Hospital Quality Star Ratings - YES CMS could consider using a simplified, pre-defined approach that specifies or fixes the contributions or weights of each measure in a measure group. We support this approach and see little value in including measures that have very low weights. We recommend a more evenly distributed weighting system. Generally, we feel the scoring methodology should be simplified overall for ease of understanding and spread.	Holly Wolfe, MBA, Director, Quality & Clinical Improvement, WellSpan Health	hwolfe2@wellspan.org	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>Our broad view is that, even though more complex, a data-driven approach such as LVM is preferable to an approach where weights are pre-specified without clear scientific or data-based underpinnings. The LVM approach is far more flexible to addition of new measures and is somewhat more difficult to game since weights are not constant. Further, we know of no reliable way to weight these measures otherwise; consensus approaches might be attempted, but this difficult process would have to be repeated any time a measure is added or removed, creating significant limitations on progress in measuring performance.</p> <p>If the goal to have balance across measures, then there is little reason to define this empirically using complex statistical models; the goal is clear, and this could be done by simply pre-specifying equal weights for the measures. Exploring additional options such as empirical Bayes estimators may be worthwhile.</p> <p>While an explicit approach seems reasonable, we have a number of concerns about such an approach. Achieving consensus on weights of over 50 measures amongst a diverse set of stakeholders will be difficult. Additionally, as measures are added and dropped, the entire process will need to be repeated. Further, this approach is not likely to be data driven. As in your example, different weights on the same measure set would put a hospital in a totally different Star rating. LVM has its limitations, but it is data driven and does not rely on biased human assignation of weights to the measures in a group. It is possible to envision a hybrid process where LVM is used to develop a range of weights under different assumptions, and those weights are brought to stakeholders for discussion and consensus on which weighting methodology should be used (similar to the presentation done for this call).</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	svijan@med.umich.edu	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	CMS seeks feedback on using a simplified, pre-defined approach that specifies or fixes the contributions or weights of each measure in a measure group. Kaiser would support the adoption of an explicit, pre-defined approach to calculation of the ratings, as this will help stakeholders predict and target improvements. This is also the approach used for the Medicare Advantage and Part D Star Ratings, as well as other hospital quality report cards, which we support.	Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals	andy.m.amster@kp.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Explicit Approach	A more explicit approach would be much easier to understand for both consumers and hospital staff. Hence, Cedars-Sinai supports the proposal for explicit scoring. An added advantage to this approach is the support of quality improvement efforts by providing the ability to discern what actions could improve the overall Star Rating. The challenge in implementing this approach, however, would be establishing what the weights for each measure should be. This illustrates one of the reasons why the concept of an Overall Hospital Quality Star Rating is of limited usefulness: individuals differ in their concepts of quality. One person may not care about Patient Experience as long as Mortality is low. Another person may think that Patient Experience is the only way to differentiate among hospitals. Another person may value minimizing the chance they will get a healthcare associated infection.	Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center	gail.grant@cshs.org	Hospital	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>5.2. Explicit Approach</p> <p>What are the advantages and disadvantages of a more explicit approach to calculating Overall Hospital Quality Star Ratings?</p> <ul style="list-style-type: none"> The advantages and disadvantages are adequately presented in the Overall Hospital Quality Star Rating on Hospital Compare Public Input Request. As mentioned above, we believe that an explicit approach may be appropriate if the LVM does not work out to our satisfaction. <p>Is the explicit approach a worthwhile change in approach and direction to consider further?</p> <ul style="list-style-type: none"> Yes. See above the answer to question above. 	<p>Jeremy Boal, MD Chief Clinical Officer Executive Vice President Mount Sinai Health System</p> <p>Vicki LoPachin, MD Chief Medical Officer Senior Vice President Mount Sinai Health System</p> <p>G. Troy Tomilonus Vice President, Clinical Decision Support Mount Sinai Health System</p>	troy.tomilonus@mountsinai.org	Hospital	Please refer to the Summary Report
3/29/2019	Explicit Approach	In the long term, CHA: Believes a less complex, “explicit” approach to scoring hospital star ratings may be the most promising option for improving star ratings. The current methodology has led to an inaccurate and potentially biased picture of hospital quality. In addition, the use of such a statistically intensive methodology makes the ratings of virtually no use to hospital quality improvement efforts and must be revisited.	Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association	nhoffman@calhospital.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Explicit Approach	However, as we explain in-depth elsewhere in this letter, we suggest that the latent variable approach be retired in favor of more explicit metric weighting	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	Using statistical tests to determine if an important latent quality trait is represented by the measures in the group While we appreciate that CMS sought to improve the consistency and predictability of individual measures while also reducing the star ratings' sensitivity to other measures, we do not see that this has been accomplished. A simpler, more consistent, explicit weighting approach should be explored. Understanding that the star rating is intended to be a tool for the patient or caregiver, many hospitals strive to provide the highest level of patient care. The current CMS star rating approach using latent variable modeling does not allow hospitals to meaningfully develop a strong understanding of where they can improve patient care, hampering hospitals' quality improvement efforts while increasing administrative cost burden to the system.	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	Explicit Approach to Calculating Overall Hospital Quality Star Ratings Any responsible hospital or health system has an inherent desire to improve patient care and quality outcomes. The current CMS star rating approach using latent variable modeling, though statistically valid, does not allow hospitals to meaningfully develop a strong understanding of where they can improve patient care. In fact, because the weighting of each metric fluctuates between each report under the current methodology, a hospital could make significant improvement in a majority of its patient safety/readmission/mortality/experience metrics and still receive fewer stars in the next CMS release2. In 2016, the American Hospital Association, Association of American Medical Colleges, America's Essential Hospitals, and the Federation of American Hospitals issued a joint letter5 to CMS describing some of the issues with the latent variable approach, including that "the assignment of weights to measures and to groups of measures is completely	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>arbitrary, and yet it likely has a significant impact on the number of stars assigned to each hospital”. This arbitrary weighting and its subsequent fluctuations with each new star rating release are the core issues of the current methodology, but they are also the most simple to address. There are many alternatives which could incorporate an explicit weighting approach for pre-identified metrics. Although we have not developed any specific alternative approach, we would generally support the transition away from the latent variable approach to a validated, well-documented, reproducible, and explicit statistical approach.</p> <p>2. Castellucci M. CMS hospital star-rating system has been wrong for two years, health system finds. Modern Healthcare. 2018.</p> <p>5. Joint Hospital Association Letter to Patrick Conway. 7 July 2016. https://www.aamc.org/download/463044/data/jointhospitalassociationlettertopatrickconway.pdf.</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>1. 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>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<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> <p>CMS seeks input on alternative approaches to LVM, such as an explicit approach, that assign weights to each measure in each group, independently of the performance distribution or relationships between measures. The program would benefit from a simplified methodology, for better hospital and patient understanding. An explicit approach warrants further evaluation and consideration to identify what challenges or unintended consequences might exist related to this approach. For example, if pre-specified, differing weights are used in lieu of equal weights, stakeholders must come to a consensus on which measures to weigh more heavily.</p> <p>Overall, the methodology used for the star ratings should reflect true differences in quality and must ensure accuracy, reliability, and fairness. Further, patients should feel confident that the rating they use to make care choices is a true reflection of quality. We urge CMS to examine an explicit approach to the star ratings calculations that will provide transparency and understanding to providers and patients.</p>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	The Joint Commission is in favor of the consideration of an explicit approach to calculating Overall Hospital Quality Star Ratings instead of using a statistical model to determine a hospital's measure group score. Using such a simplified approach could potentially make the methodology more transparent and make it easier for a hospital to determine the reasons for its rating and how it could improve its rating in the future. An explicit approach would be easier to explain, more clinically driven, and potentially less susceptible to variations in the data.	Patrick Ross, MPH Federal Relations Specialist The Joint Commission	PRoss@jointcommission.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Explicit Approach	NJHA believes a less complex "explicit" approach to scoring hospital star ratings may be the most promising long-term option for improving star ratings. CMS's current approach to star ratings employs complex statistical modeling techniques (i.e., LVM, k-means clustering). We appreciate that CMS's intent in using these techniques was to create a rating that accounts for as many statistical vagaries as possible across the highly heterogeneous measures included in star ratings.	Jonathan Chebra, Senior Director, Federal Affairs, New Jersey Hospital Association	JChebra@NJHA.com	Hospital Association	Please refer to the Summary Report
3/29/2019	Explicit Approach	Explicit approach to star ratings. MHA believes a less complex "explicit" approach to scoring hospital star ratings may be the most promising long-term option for improving the ratings. CMS's current approach to star ratings employs complex statistical modeling techniques (i.e., LVM, k-means clustering). We appreciate that CMS's intent in using these techniques was to create a rating that accounts for as many statistical vagaries as possible across the highly heterogeneous measures included in star ratings. Yet, as we 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. It is inscrutable even to educated consumers. CMS has indicated in the past that it views star ratings as a tool for patients that is 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. For these reasons,	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Explicit Approach	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. For these reasons, we encourage CMS to continue exploring a more explicit approach to star ratings. We acknowledge that any more explicit system would involve some choices about what measures to include, how to weight particular measures, and what performance targets to set. But 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. The current process is not consumer friendly or mindful of how the public wants to receive information. If anything, ambiguous ratings will force consumers to find easier explanations elsewhere that tend to be rooted more in anecdotes than valid and reliable methodologies. Other reporting groups may not hold themselves up to the same standards to which CMS strives. 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.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Explicit Approach	5.2 Explicit Approach to Calculating Overall Hospital Quality Star Ratings: Not in favor. Rather support current and enhanced methodology that should be implemented for all hospitals. Explicit approach leads to regulatory capture.	Dale N. Schumacher, MD, MPH, President, Rockburn Institute	dale.schumacher@rockburn.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Explicit Approach	CMS seeks input on alternative approaches to LVM, such as an explicit approach, that assign weights to each measure in each group, independently of the performance distribution or relationships between measures. The program would benefit from a simplified methodology, for better hospital and patient understanding. An explicit approach warrants further evaluation and consideration to identify what challenges or unintended consequences might exist related to this approach. For example, if prespecified, differing weights are used in lieu of equal weights, stakeholders must come to a consensus on which measures to weigh more heavily.	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Explicit Approach	Overall, the methodology used for the star ratings should reflect true differences in quality and must ensure accuracy, reliability, and fairness. Further, patients should feel confident that the rating they use to make care choices is a true reflection of quality. We urge CMS to examine an explicit approach to the star ratings calculations that will provide transparency and understanding to providers and patients.	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>CMS seeks input on alternative approaches to LVM, such as an explicit approach, that assign weights to each measure in each group, independently of the performance distribution or relationships between measures. The program would benefit from a simplified methodology, for better hospital and patient understanding. An explicit approach warrants further evaluation and consideration to identify what challenges or unintended consequences might exist related to this approach. For example, if prespecified, differing weights are used in lieu of equal weights, stakeholders must come to a consensus on which measures to weigh more heavily.</p> <p>Overall, the methodology used for the star ratings should reflect true differences in quality and must ensure accuracy, reliability, and fairness. Further, patients should feel confident that the rating they use to make care choices is a true reflection of quality. We urge CMS to examine an explicit approach to the star ratings calculations that will provide transparency and understanding to providers and patients.</p>	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinaui.org	Health System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>Given the LVM inconsistencies, VCU Health System supports creating a similar, consistent hospital evaluation program for both patients (Hospital Star Ratings) and providers (VBP, HRRP, HACRP).</p> <p>From a practical perspective, latent variable modeling is difficult to understand and explain. Many providers who are attempting to use the Overall Star Rating as a guide for performance improvements have an extremely difficult time understanding and explaining why the loading coefficients change each quarter, and where they should focus their efforts. While VCU Health System supports providing actionable information to providers and consumers to assist in their health care decisions, transparency and improving care must strike a delicate balance. Information should be readily available to patients for the purposes of improving quality in health care, expanding consumer engagement in health care decision-making, and to improve federal programs' administration of health care benefits.</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>	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	eryn.leja@vcuhealth.org	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	We share Rush University Medical Center's concerns that the latent variable modeling approach creates consumer confusion, allows for measure groups such as Readmissions and Safety of Care to be essentially dominated by just one measure, and leads to vast differences in star rating distributions by hospital size. Therefore, we agree with the proposal to discard latent variable modeling in favor of explicit measure weighting.	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report

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3/29/2019	Explicit Approach	Abandon black box statistics such as the Latent Variable Model, to a more explicit approach, where measures have known weightings. This would make it easier for hospital leaders and consumers to interpret drivers of performance. Weightings should be established by expert panels with public input and reviewed annually. If the Latent Variable Model is retained in the methodology, we encourage additional testing to determine if the incorporation or removal of a measure changes the distribution of the loading coefficient weightings or if the measure group is dominated by a single measure. For example, in the February 2019 release, the PSI-90 was almost perfectly correlated with the safety domain score, while the six HAI measures had very low loading coefficients, indicating that they only had a minor influence on the safety measure group overall score. The PSI-90 and THA-TKA complications almost completely dominate the safety measure group.	Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health	Tony.Calabria@Medstar.net	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	Explicit Approach to Calculating Overall Hospital Quality Star Ratings Given the rapid improvement and introduction of measures over time, it is important that the methodology be able to autonomously adjust weights as measures are added/subtracted/changed. Getting stakeholders to agree on weights a priori before every release is impractical. At the same time, adopting a simple procedure such as spreading weight evenly is problematic because most would agree that some measures are more important than others. Why are some measures more important? There are clinical differences, but also the span of the population impacted by some measures is greater than others. The weights on measures should also depend on benchmark- ing against best performing hospitals. The approach I propose allows measure weights to change autonomously using such principles that are relatively easier to understand than the LVM, and make future weights easier to predict.	Dan Adelman, Professor, University of Chicago Booth School of Business	Dan.Adelman@chicagobooth.edu	Individual	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>An explicit approach would be worthwhile because it would make healthcare facilities feel like there is less of a moving target, and it would help consumers understand how the score is created without a lot of statistical mumbo jumbo. It would also help CMS quickly evaluate which measures have been maxed out in performance and need to be retired or altered. As we reference in Section 2.8, a competency model would be most equitable, and would drastically improve the fairness of a score, and would let you lower the minimum required domains from three to two if you implemented a system similar to what is proposed in that section. This approach would also help CAH hospitals that struggle to get a star rating at least get on the board. However, we did have one user suggest that a star rating should continue to be on a curve because it increases competition, which ultimately raises the level of care nation wide.</p> <p>An explicit approach also has the ability to single out measures for improvement on an annual basis, which would be antithetical to the purpose of the quality rating posted on Hospital Compare and to stability of the system.</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report
3/29/2019	Explicit Approach	<ul style="list-style-type: none"> • The advantages are a scoring system that is easier to understand and metric goals that are more clearly established. We are strong supporters of this approach. • Yes. Other quality programs use this and I feel it is easier to understand, explain, and set goals for improvement. • We would suggest establishment of an interdisciplinary group to develop the weighting system. This group would need to explain their rationale clearly. Would need to meet once a year to discuss any changes. 	Jean Cherry, FACHE, Executive Vice President, Med Center Health	jean.cherry@mchealth.net	Healthcare System	Please refer to the Summary Report
3/29/2019	Explicit Approach	<ul style="list-style-type: none"> • Support the concept, which will increase the stability, predictability, fairness, transparency • It's better than LVM since it removes the black-box challenge that exists in LVM. • Keep evaluating available measures and weights, like VPB 	Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center	deede.wang@vumc.org	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	Vizient continues to urge CMS to discontinue using Latent Variable Modeling (LVM) and instead leverage a more explicit, easier to understand measure weighting – similar to the current precedence the agency has set to use explicit measure weighting in its pay-for-performance programs which Vizient also leverages in our own Quality and Accountability Hospital Ranking methodology. Based on our assessment, CMS is in a statistical predicament where the current 1-	Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.	Chelsea.arnone@vizientinc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>factor modeling approach does not create reliable results, but the more statistically appropriate techniques are too complicated to understand. To mitigate this analytical conundrum, Vizient encourages CMS to consider a more simplistic approach, similar to existing pay-for-performance programs (e.g., the Hospital Readmissions Reduction, Value-Based Purchasing, and Hospital-Acquired Condition Programs). In these programs, the measure sets are clearly defined, with standard weights for each measure evaluated. Vizient strongly believes that this approach would not only improve scoring understanding, but also provide consistency among the CMS performance evaluating programs. Vizient's recommendations are intended to improve the Star Rating's accuracy and clarity for patients, as well as to create important feedback for providers for performance improvement.</p> <p>Vizient recommends continuing with the existing measure groupings, and substituting latent variable modeling for a more explicit, easy to understand measure weighting approach.</p> <p>Despite the various adjustments and alternative ideas to improve the latent variable modeling approach, the measure loading coefficients continue to generate inconsistent and clinically counter-initiative results by penalizing hospitals that provide better care. Vizient is supportive of CMS exploring alternative measure weight approaches and supports an explicit measure weighting approach due to its clear, straight-forward application, which will be easy for providers and the public to understand. Grouping hospitals by complexity of patients seen and services provided creates inherent weighting adjustments by simply comparing a hospital to members of its peer group. When a hospital is missing a measure, Vizient suggests distributing the weight from the missing measure to the other measures within the domain. A minimum number of measures would be required to receive a score in that domain. Vizient believes any disadvantages, such as measures being removed or differences in hospital volume, in the explicit weighting approach pale in comparison to the challenges CMS has faced by using latent variable modeling. Thus, coupled with hospital peer grouping, Vizient recommends CMS explore an equal weighting approach that is similar to those used in the current pay-for-performance programs to create clear expectation of measure performance.</p>	Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.	Chelsea.arnone@vizientinc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>An effective quality measurement program enables hospitals to clearly understand where to focus and drive improvement. Premier believes the program would benefit from a simplified methodology using an explicit approach to enable hospital and patient understanding. CMS could consider modeling the star rating after a program such as the Hospital Value Based Purchasing (HVBP) program that incorporates both achievement and improvement, allowing low-performers to rise rather than stagnate at the bottom. HVBP has proved to be an effective vehicle because it is a well understood, tested method that addresses many of the flaws in the other programs. Converting HVBP performance to a star rating could ensure comprehension for hospitals and patients.</p> <p>If CMS chooses to utilize pre-specified differing weights, instead of equal weights, there should be broad stakeholder agreement on which measures to weight more heavily. Additionally, the agency might consider a “harm-based” weighting similar to the methods employed in the AHRQ PSI-90 component weighting.</p>	Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance	aisha_pittman@premierinc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>MGH applauds the use of statistically robust methods and believes that from a statistical perspective the latent variable model is a very appropriate, though complex methodological approach. However, MGH also understands the concerns of many stakeholders who desire a less arcane, more explicit approach. MGH supports investigations of such alternative approaches and their comparison to the current latent variable modeling. As several years of data are now available, it would be possible to examine retrospectively how such alternative approaches would have impacted the sensitivity of the overall score to period to period changes in individual measures, consistency of scores over time, and measure interpretability.</p>	Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital	emort@partners.org	Medical University	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>The FAH strongly supports replacing LVM with a simpler, more explicit approach to group score calculations that yields a more intuitive and predictable approach to describing hospital quality performance. CMS currently uses a latent variable modeling (LVM) and k-means clustering to compress 57 measures into 5-star ratings. The complexity of the LVM model and combined k-means clustering, while methodologically elegant, leads to unpredictability of the group scores from reporting period to reporting period. This makes it difficult for hospitals to understand the current factors contributing to those scores and take appropriate actions, limiting its utility as an approach for scoring measures and measure sets intended for performance rating.</p> <p>These methods have also resulted in misleading ratings of hospital quality which does a disservice to patients, their caregivers and the facilities being measured. The rating should be intuitive with directionality of performance measure scores for it to be actionable for hospitals. The relationship between a final score and the measures that are its building blocks should not be inscrutable nor should future performance be unpredictable for the organization being measured. The advantages of a more explicit approach to Star Ratings include predictability that allows hospitals to estimate their future performance.</p> <p>An explicit approach would be an improvement over the LVM, and FAH recognizes that this will require policy decisions when applying weights and including measures. However, as far as specific approaches, the FAH cautions against a simple averaging approach, in particular, if no confidence intervals are used.</p>	Chip Kahn, President, CEO, Federation of American Hospitals	csalzberg@fah.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Explicit Approach	<p>From a practical perspective, latent variable modeling is difficult to understand, replicate, and explain. Attempting to use the Overall Star Rating as a guide for performance improvement is extremely difficult as it is hard to understand and explain why the loading coefficients change, and where efforts should be focused. Given the questionable application and the difficulty in interpreting results from latent variable modeling, Christiana Care urges CMS to remove latent variable modeling from the Overall Hospital Quality Star Rating completely; and in its place, apply a consistent explicit measure weighting approach (similar to the CMS pay-for-performance programs). This would provide scoring stability and markedly easier interpretation for hospitals and the public.</p>	Delilah Greer, MPH, Director of Data Informatics and Analytics; Christiana Care Health System	dgreer@christianacare.org	Healthcare System	Please refer to the Summary Report

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3/29/2019	Explicit Approach	<p>The advantage of a more explicit approach is its simplicity and ease of understanding. LVM is not an intuitive model and the loadings may change over time depending on the data available at the time. Thus, hospitals cannot predict how they will perform on any measure or take any policy action to focus on specific set of measures. For these reasons, AHPA believes that the explicit approach would offer more transparency and predictability. AHPA believes it is the right course of action for CMS to take.</p> <p>The determination of weights needs to consider measures that are more critical and thus require higher weights. While weights should be tailored to the measure set, they should also remain balanced across a measure group to avoid placing too much emphasis on any one measure. No one metric should be weighted much more or much less than the others.</p>	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report
3/29/2019	Explicit Approach	Although we appreciate CMS's desire to remove arbitrariness from the data-driven latent variable model approach, the "explicit" approach outlined appears to trade one arbitrary process for another. A datadriven solution that summarizes quality in the ways outlined above would be superior.	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	However, we believe that only three of the proposals should be pursued further at this time:...3) using an "explicit" scoring approach.	Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources	joelballew@texashalth.org	Healthcare System	Please refer to the Summary Report
3/29/2019	Explicit Approach	Yes. The current latent variable method, while statistically meaningful, contributes to fluctuations in measure weights and thus to fluctuations in hospital scores that do not contribute to an overall understanding of the quality and safety of care provided. An explicit approach, adjusted to reflect national patient populations, will encourage prioritization of improvements of most importance to the patients receiving care, and will allow organizations to make comparisons over time in order to monitor progress. Additionally, a consistent methodological approach across CMS reporting programs (Overall Hospital Quality Star Rating, Value Based Purchasing, Readmissions Reduction Program, Hospital Acquired	Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care	hahncoverk@health.missouri.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Explicit Approach	Conditions Reduction Program) at the measure level will contribute to a better understanding of a hospital's quality of care, among patients and consumers.	Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care	hahncoverk@health.missouri.edu	Medical University	Please refer to the Summary Report
3/29/2019	Explicit Approach	CMS states that it is considering replacing the latent variable model for deriving measure group scores with an “explicit” approach. There would be trade-offs—the latent variable model produces statistically derived measure weights, while an explicit approach would rely on CMS-defined measure weights. While we conceptually prefer empirically derived measure groups, we are somewhat skeptical that CMS will be able to adequately improve the sensitivity, validity, and reliability of the latent variable models to address the concerns we have identified with the current models. For example, based on our preliminary exploratory factor analysis, there is evidence that the measures in the Safety of Care group do not share an underlying latent variable. Further, our analysis could not produce an optimal subset of measures with a common latent trait. We therefore encourage CMS to explore an explicit approach to developing star ratings as an alternative. This approach may also improve transparency for stakeholders, both providers and consumers alike.	Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association	achin@gnyha.org	Hospital Association	Please refer to the Summary Report

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3/14/2019	Clustering Alternatives	<p>HFHS believes that a better approach to stability over time would involve a larger re-thinking of the Star Rating system - moving it from a "tournament model" of constantly-changing relative performance to a system based on fixed, pre-set criteria for the five levels of performance. For example, each measure can be characterized now by quintiles of performance. A very simple Star Rating system could be created by calculating a weighted average (measures weighted by clinical significance) of quintile scores for all measures in a given hospital. A hospital that has all measures in the top quintile is a five-star hospital. A hospital that has all measures in the worst quintile is a one-star hospital. Since the hospital averages will obviously be on a continuous distribution, some method would need to be created to create cut points, but this would be the general idea.</p> <p>Then, rather than constantly ranking hospitals against each other, the cutpoints for defining different Star levels could be held constant for periods like five or even ten years. A hospital could know very clearly then, what it would take to move into a higher Star category. Over periods of time like five or ten years, it would be both expected and desirable that the hospital distribution would shift upward, with eventually more hospitals in the upper end of the Star distribution and fewer in the lower end. As long as the measures, weighting, scoring, and cutpoints were fair and clinically defensible, this would all be good. It would indicate that individual hospitals, and hospitals in general, are getting better. That kind of phenomenon is impossible to detect now in the Star Rating system.</p> <ul style="list-style-type: none"> Should CMS consider potential alternatives to k-means clustering in more detail? <p>Yes</p> <ul style="list-style-type: none"> If so, what sort of change should CMS consider? <p>As noted earlier, we would favor the setting of explicit cutpoints on measures or</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report

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3/14/2019	Clustering Alternatives	<p>measure groups to establish eventual global Star Rating scores rather than the current k-means clustering approach that pits all hospitals against each other in a "tournament model." By combining explicit cutpoints for assigning stars at the category level into a set of four explicit cutpoints for assigning global stars, a clearer and more transparent and more user-friendly system could be created. We would favor a system like this in which the criteria for achieving each Star level was set in advance, kept in place for some period of time, with the resulting distribution of ratings allowed to shift upwards as hospitals in general improve their performance</p> <p>-What other considerations should guide future CMS work regarding clustering? HFHS encourages CMS to re-think the fundamental rationale for cluster ing and the creation of five groups. Currently, the approach emphasizes relatively obscure statistical methods to build on a concept (that does not have any strong empirical support) of a single underlying dimension of quality on which hospitals differ and can be categorized. From that perspective, the methods are sound and sophisticated and probably successful. The key problem, though, is that they are opaque to users of all kinds, and they do not allow for hospitals to focus and monitor QI activities with any confidence in how success in QI will translate into any future improvement in Star Ratings. In the future, a much more useful, transparent, and successful Star Rating system could be based on a simple set of explicit weights and combination and grouping rules that CMS, or any other user, could manipulate in Excel once in possession of the data on individual measure scores.</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report
3/21/2019	Clustering Alternatives	<ul style="list-style-type: none"> Should CMS consider potential alternatives to k-means clustering in more detail? <p>The only concern with k-means clustering is if it inherently requires hospitals to be split into groups. Any clustering method should allow all hospitals to receive the rating they deserve. Theoretically, a clustering model should allow all hospitals to have the same rating if there is very little variance in scores.</p>	Jennifer Lamprecht, MS, RN, CNL, CPHQ Director Quality Strategy Sanford Health	Jennifer.Lamprecht@SanfordHealth.org	Health System	Please refer to the Summary Report

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3/22/2019	Clustering Alternatives	We also support CMS considering alternatives to clustering. Currently, there are no standards for CMS stars that are independent of other hospital performance. Nor does CMS tie STARS to any minimum performance in metrics.	Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University	bruce.meyer@jefferson.edu	Health System	Please refer to the Summary Report
3/25/2019	Clustering Alternatives	For the future, CMS should consider explore alternatives to k-means clustering	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/25/2019	Clustering Alternatives	The current use of k-means clustering to assign an Overall Star Rating makes it difficult for BHS to predict our future rating. Currently, our assignment of a star rating depends on the relationship of our summary score with the summary score of other hospitals.	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/27/2019	Clustering Alternatives	MHA appreciates the opportunity to comment and believes CMS should consider potential alternatives to k-means clustering in detail. MHA previously commented that k-means clustering typically is used for classifying observations based on a profile of multiple dimensional measures. In the Overall Star Ratings, hospitals are classified based on a single dimensional measure and, in essence, uses an algorithm to define four cut-points to apply to a single continuous measure. We agree with stakeholders that this result seems unnecessarily arbitrary versus explicit, predefined cut-points defined based on stakeholder input.	Herb B. Kuhn, President, CEO, Missouri Hospital Association	DLandon@mhanet.com	Hospital Association	Please refer to the Summary Report
3/28/2019	Clustering Alternatives	Should CMS consider potential alternatives to k-means clustering in more detail? If so, what sort of change should CMS consider? The concept of clustering assumes the validity of a forced bell curve solution. The star system should use a more explicit and linear approach as outlined in the comments above.	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report

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3/28/2019	Clustering Alternatives	<p>Yes, alternatives to k-means clustering should be evaluated and adopted. Clustering makes the star cutoffs variable each period. Hospitals cannot easily determine if they improved 'X' on a measure would they reach the next star level.</p> <p>Alternatives:</p> <p>A) Known cut-offs: This would be the most simple and straight forward method and is very similar to grading in school. Known cut-offs would give hospitals the chance to know if they obtain a certain measure performance they would achieve a 5-star rating (receive an 'A'). A possible drawback of this solution is that as all hospitals get better more and more hospitals will be in higher grades. This might be acceptable because it still means all hospitals improved in quality. Star cut-offs could be escalated in the future with significant communication to hospitals and consumers prior to changes.</p> <p>B) Known distribution: This is like Known cut-offs but grading on a curve. For example top 20% receive 5-star, next 20% 4-star, next 20% 3-star, next 20% 2-star, and last 20% 1-star. While cutoffs won't be known, everyone will know clearly what % of hospitals received what star ranking. These distributions could be tweaked for more 2/3/4 stars, based on expert opinion.</p> <p>C) Known cut-offs with normalization: Normalizing the overall score will address star rating inflation. This may be only slightly better than current clustering because, post normalization, each hospital's score depends on how every other hospital performed and would be hard to estimate.</p>	<p>Dr. 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 Chicago, Illinois Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center</p>	<p>Thomas_A_Webb@rush.edu</p>	Medical University	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*
3/28/2019	Clustering Alternatives	<p>Clustering Alternative: CMS should consider alternatives to the current k-means clustering, with a focus on an approach that allows for predictable, fixed targets. Clustering Alternative</p> <p>Currently, CMS uses a k-means clustering method to assign hospitals to a discrete Star Rating category. This approach was originally used to avoid arbitrary cut points, accommodate changes to the underlying distribution of scores, and to provide a comparative assessment for patients. However, such an approach also limits hospitals' ability to predict cut points for future releases and seems arbitrary for hospitals with borderline scores. CMS seeks feedback on whether it should consider potential alternatives to k-means clustering and what sorts of changes. In many other areas of performance measures, those being scored have knowledge of a fixed target one must achieve in order to meet the "grade" one desires. The AAMC believes that a "line of sight" between a hospital's performance and its star rating is critical to the future utility of the Overall Hospital Quality Star Ratings continuing to motivate quality improvement. Explicit predictable scoring targets are key drivers for hospitals to invest in meaningful improvement activities. To that end, we believe that CMS should consider alternatives to the current k-means clustering, with a focus on an approach that allows for predictable, fixed targets.</p>	Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	We believe that CMS should consider not clustering, but instead incorporation of individualized risk adjustments to equalize the scoring.	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	In response to CMS's request for input on whether it should consider alternatives to the current clustering method, we agree that clustering makes it difficult to proactively analyze future ratings improvements. CMS may consider instead not clustering, but more incorporation of individualized risk adjustments to equalize the scoring (bed size, safety net status, teaching status, dual eligibility/disproportionate care, etc.).	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	Alternatives for assigning star rating predefined criteria. CMS should explore this interesting potential change. It would help hospitals understand why they received a certain star rating if each of the star ratings had upper- and lower-defined score ranges. It would also help hospitals prioritize improvement work and understand the level of ease or difficulty in moving from one star rating to the next.	Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic	deylingc@ccf.org	Medical University	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	RWHC believes the current method of clustering makes it difficult to predict a hospital's rating in future periods because the assignment of star ratings for any one hospital depends on the relationship of that hospital's summary score with the hospital summary scores of other hospitals. RWHC would be in favor of pre-set cutoffs that would allow hospitals to better predict the publicly reported star rating.	Tim Size, Executive Director, Rural Wisconsin Health Cooperative	JLevin@rwhc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	DHR appreciates CMS' thoughts on changes to methodologies in assigning hospital star-ratings. Specifically, DHR agrees with CMS' consideration of changing the current "clustering" method to one that assigns star-ratings based on individual performance. DHR believes that the current clustering method results in hospital star ratings being assigned based on hospital performance in relation to the performance of other hospitals instead of individual performance. Hospital Compare star-ratings based comparatively on other hospitals' performances may inaccurately capture the performance of an individual hospital. Additionally, clustering makes it difficult for hospitals to predict their own star rating, as hospitals cannot compare their own data to other hospitals' data. It is also extremely difficult for hospitals to determine their rating when they potentially have borderline (i.e. in between two rating categories) scores. OHR strongly urges CMS to reconsider its clustering method, as it may result in unfair and inaccurate ratings. Instead, hospitals should be rated based only on their individual performance.+ [...] hospitals to predict their own star rating, as hospitals cannot compare their own data to other hospitals' data. It is also extremely difficult for hospitals to determine their rating when they potentially have borderline (i.e. in between two rating categories) scores. DHR strongly urges CMS to reconsider its clustering method, as it may result in unfair and inaccurate ratings. Instead, hospitals should be rated based only on their individual performance.	Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health	kkincaid@appliedpolicy.com	Hospital	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	<p>The approach to dividing hospitals into groups, in our view, is dependent on the underlying goals of the process. For example, if there is a belief that there should be a flat, normal, or some other distribution of scores, then there is no particular reason to use clustering.</p> <p>Clustering methods make sense if there is a reason to believe that there are distinct groupings; however, we have not seen data suggesting that this is the case. Instead this seems to be a way to set a cutpoint of a fairly continuous variable. However, all methods of setting cutpoints have a degree of arbitrariness, so clear definitions are essential. There will always be those at the margins of a grouping that will be unhappy, regardless of the means chosen.</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	svijan@med.umich.edu	Medical University	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	Cedars-Sinai supports the current k-clustering method of assigning star ratings. In the context of the current methodology, the k-means clustering seems appropriate.	Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center	gail.grant@cshs.org	Hospital	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	CMS seeks input on alternatives to the current clustering methodology given some stakeholders' concerns that clustering makes it difficult to predict future ratings because the assignment of star ratings for any one hospital depends on the relationship of that hospital's summary score with the hospital summary scores of other hospitals. We believe it is appropriate to consider alternatives to clustering, but we firmly believe any change must be subject to public review and comment with sufficient time before implementation. We suggest that CMS consider the clustering approach used in 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	andy.m.amster@kp.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	<p>5.3. Clustering Alternative</p> <p>Should CMS consider potential alternatives to k-means clustering in more detail?</p> <ul style="list-style-type: none"> We support the k-means clustering methodology to assign overall star ratings. 	<p>Jeremy Boal, MD Chief Clinical Officer Executive Vice President Mount Sinai Health System</p> <p>Vicki LoPachin, MD Chief Medical Officer Senior Vice President Mount Sinai Health System</p> <p>G. Troy Tomilonus Vice President, Clinical Decision Support Mount Sinai Health System</p>	troy.tomilonus@mountsinai.org	Hospital	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	<p>In the 2018 star rating methodology report6 results of a 5,000-run simulation to re-classify star ratings were given in Table 8. Critically, results showed that 5-star hospitals were only re- classified as 5-star hospitals in 67% of these simulation runs. This suggests that in any given CMS star rating release, it can be said that roughly one-third of all 5-star hospitals may have achieved their 5-star rating by random error alone, and could be more accurately be assigned a 4-star rating. Conversely, 1-star hospitals were re-classified as 2-star hospitals in 22% of these simulations, meaning that one-fifth of 1-star hospitals are potentially 2-star hospitals due to random error. Given these somewhat low reliability rates, and similar to our prior comments about using an “explicit approach” rather than the latent variable model, we have not developed any specific alternative statistical approach to clustering. However, we would generally support any well-documented, reproducible, and explicit statistical approach to more reliably give equivalent-quality hospitals an equivalent quality rating.</p> <p>6. CMS. Overall Hospital Quality Star Rating on Hospital Compare Methodology Report (v3.0). December 2017. Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (YNHHSC/CORE).</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	The Joint Commission supports considering alternatives to k-means clustering in more detail. This may, for example, include consideration of changing the scoring system to the use of absolute standards within each measure grouping, and considering whether the measure grouping summary measure significantly exceeded, met, or was significantly lower than the standard after incorporating each individual performance measure's precision.	Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission	PRoss@jointcommission.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	CMS solicits input on whether the agency should consider alternatives to the current clustering method and what factors should guide any future work with regard to clustering. Ascension believes k-means clustering is a very appropriate method for grouping the LVM hospital summary scores into the 5-star rating categories. While the k-means analysis does derive clusters based on the relative distribution of the summary scores, this effect is minimal and of little relevance for a hospital to be able to "predict" future performance. A hospital's relative performance is truly driven by the LVM and no change in the cutoff methodology will improve the "predictability" of the method.	Peter M. Leibold, Chief Advocacy Officer, Ascension	Danielle.White@ascension.org	Health System	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	To that end, we propose an alternative strategy to k-means clustering whereby cut points are pegged to some set of explicit (i.e. non-normalized) performance measures in the first year and then carried forward for at least the following year. In this way, hospitals would have clear improvement benchmarks moving forward.	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report
3/29/2019	Clustering Alternative	4.Utilize alternatives to the k-means clustering process. This process makes the Star cutoffs variable for each period. Hospitals cannot easily determine if improvements were sufficient for moving to a different Star Level. Set cut-offs would be a simple and straightforward method for setting a bar for excellence while allowing hospital leaders to use defined cut-offs to set goals for improvement. For example, a 2 Star Hospital could set a goal of moving up a Star every 3 years and use preset cut-offs to layout yearly goals. As hospitals improve, guidelines should be established for periodic adjustment to the cut-offs, but this process should not be random or unexpected to avoid hospitals not having enough notice to build such changes into their quality improvement plans.	Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health; Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health	Tony.Calabria@Medstar.net	Health System	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	If stars must be assigned, then I would advocate using quintiles on the premise that with k-means clustering, a hospital may improve (worsen) their score quintile but still receive a lower (higher) star rating. The goal posts shouldn't keep changing.	Dan Adelman, Professor, University of Chicago Booth School of Business	Dan.Adelman@chicagobooth.edu	Individual	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	<p>This is a question about competency grading models vs. statistical grading models. A current trend in education and assessment is to grade to stated measurable objectives as opposed to weighted grades. For instance, say two classes both have the same ten stated learning objectives. Assume one class has no weights to the system (which means everything is equal in value) while the other class weights each objective so that a certain combination of three objectives gets you 80% of the grade. In the first system, any combination of eight objectives would guarantee an 80%. In the second system, you would be forced to do the specified three objectives to get an 80%. From a student perspective, the first system is more fair than the latter, even though they cover the same objectives. There are different ways to measure competency in this type of a system, some of which include weighting prior performance to demonstrate historical performance. Including prior performance, as you note in another section, would act like a smoothing function on the scores, and that would get rid of the potential jarring changes in scores. Our Patient Family Advisory Council noted that they like the competency approach mentioned above, but suggested that no level of specificity would be enough for every facility. They also noted that this approach would lead to a measured approach to driving improvement in measures nation-wide, which is the purpose of an Overall Hospital Quality Star Rating.</p> <p>One user was really adamant about having a star rating for each domain individually and then rating hospitals in a two-dimensional respect with area using the “cross the specified threshold, get this score” type of an approach. Doing something like this would allow the conversation about weighting to practically be moot because any permutation of the same scores across domains would lead to the same overall score, which makes the score stable. Additionally, this would include the idea that there is always ways for improvement. The idea is relatively simple. Let n represent the number of domains that are worked into the star rating. Then the total n-gon represents the current system measurement and performance of care that we provide. The circle that circumscribes the n-gon represents the best</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	<p>possible measurement and performance of care we could provide. The area outside the n-gon but inside the circle (in this case, the gray area) would be possible improvement in the systems of measurement of the perfect care experience. With this understanding, as n increases, we get closer to the measuring the perfect care experience.</p> <p>[Figure 3]</p> <p>Now, for each domain, a score of 1 to 5 is assigned, and then the points are connected. The final score would be the ratio of the area contained inside the domain map marked by performance to the circle. In the figure below, the domain map marked by performance is represented by the blue line.</p> <p>[Figure 4]</p> <p>It follows that the maximum ratio would always be calculated as the area of the n-gon over the area of the circle:</p> <p>[Figure 5]</p> <p>At $n = 7$, the maximum ratio is 0.871026.... Splitting this into five equal pieces and using intervals to determine scores becomes the “cross this threshold, get this score” idea. So, in this case, intervals and star ratings would be:</p> <p>[Figure 6]</p> <p>You could also choose to do the ratio out of the entire polygon, but then you end up masking the fact that there is room for improvement.</p> <p>There is one possible hiccup with something like this. It may be required to order scores highest to lowest, or visa versa, and then create domain marked by performance if you want permutations of score sets to receive the same final rating. One user suggested we set something up like rotten tomatoes, where there is a reviewer and audience rating system.</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	<p>Yes. I believe that hospitals would appreciate knowing what the cut line is for each level of star rating. An understood weighting system with an understood target would give hospitals more incentive to improve their quality metrics.</p>	Jean Cherry, FACHE, Executive Vice President, Med Center Health	jean.cherry@mchealth.net	Healthcare System	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	Although a less complex model for performance management may be preferred, MGH endorses k-clustering as part of the Star Rating methodology. Although less predictable and reproducible for hospitals, it is a statistically robust and appropriate approach.	Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital	emort@partners.org	Medical University	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	The FAH is not opposed to the use of k-means clustering as a method for stratifying. However, use of k-means clustering for assigning star ratings faces the considerable issues that CMS has identified from stakeholder feedback: 1) the inability to predict cut points is severely problematic for hospitals in a rating measure, and 2) clustering real-life, not normally distributed, messy data tends to lead to suboptimal clusters. While imperfect or non-intuitive methods of clustering work well for segmenting populations, they are flawed when it comes to establishing ratings that are publicly reported or tied to payment. For these purposes, a hospital should have a precise performance standard to target and it needs to be able to estimate its performance against that standard. If there is within-hospital consistency across quality measures over time, there should also be within-hospital consistency over time in its star rating score. Clusters should accurately reflect true differences in care. Regardless of the graphical representation, FAH urges CMS to test any changes by holding focus groups with hospitals, physicians, patients, families, and caregivers to understand how well the statistical information and displays are understood and determined to be useful by all stakeholders.	Chip Kahn, President, CEO, Federation of American Hospitals	csalzberg@fah.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	AHPA believes that the current k-means clustering is statistically sound. However, the current method limits hospitals' ability to predict cut points in future periods and these time differences or lagged effects have an influence on the star ratings assigned. One option for CMS' consideration is to conduct cross validating with Support Vector Machine (SVM) if data has already been labeled by the rating system to improve the misspecification of borderline scores with k-means. Additionally, CMS could adjust ratings with partial stars after conducting the clustering analysis for hospitals near the cut-off points. AHPA believes that the purpose of clustering is to give a sense of the underlying probability distribution of the score. For this reason, methods that are sensitive to distribution shifts should be considered, such as the Mean Shift Clustering method.	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	We believe that the k-means clustering step adds additional arbitrariness to the system; there are many hospitals on the boundary of two star ratings that are essentially equivalent, but assigned different star ratings (Figure 8 highlights this). Looking at the distribution of overall scores (before clustering), there are no clear clusters of quality. Forcing the normal distribution of continuous scores into an integer 1-5 ratings is putting a round peg into a square hole. It would make much more sense to allow for decimal ratings between 0.0 and 5.0. One could scale the final normal distribution of overall hospital scores so that the mean is equivalent to 3.0 stars.	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	<p>Questions</p> <p>a. Should CMS consider potential alternatives to k-means clustering in more detail? If so, what sort of change should CMS consider?</p> <p>b. What other considerations should guide future CMS work regarding clustering?</p> <p>Comments</p> <ul style="list-style-type: none"> • Should be more transparent. • To provide the cut points based on the distributions. e.g top 10 percentile is 5-star, 11 to 35 percentile is 4-star, etc. 	Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center	deede.wang@vumc.org	Medical University	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	Vizient appreciates that CMS has made improvements in the k-means clustering approach. Vizient has generally supported these improvements; however, we would encourage more transparency in providing cluster analysis assessment statistics and validations, such as R-square, Pseudo F, CCC statistic, ANOVA, etc. – for researchers and statisticians to make fully informed recommendations on improving the methodology.	Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.	Chelsea.arnone@vizientinc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Clustering Alternatives	<p>Premier strongly suggests that an alternative to K-Means clustering be explored for the following reasons:</p> <ul style="list-style-type: none"> • Transparency: The lack of a clear relative placement within a cluster prevents a hospital from knowing if they are borderline to a better or worse performing grouping. • Reproducibility: The need for a single hospital to have all-hospitals' data to know their own cluster placement and the inherent requirement for random centroid placement to initialize the clustering algorithm, poses difficulty to a hospital attempting to measure themselves throughout the evaluation period. <p>Furthermore, Premier recommends a simple quantile binning whereby Hospital Summary Scores are binned in equal portions as an alternative to K-Means clustering. Binning as quintiles would ease the transition by providing an analogous value between 1 and 5 and would have greater consistency with the HAC reduction rank-threshold scoring method.</p>	Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance	aisha_pittman@premierinc.com	Healthcare Performance Improvement Organization	Please refer to the Summary Report

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3/29/2019	Clustering Alternatives	<p>GNYHA supports the use of empirical methods for determining the star ratings cut points. As CMS explores alternatives to the current k-means clustering approach, we encourage CMS to consider the following:</p> <ul style="list-style-type: none"> • Groups of uneven sizes: A benefit of k-means clustering is that it allows for groups of uneven size, as long as those in the group have similar summary scores. Any alternative clustering method should also group hospitals with similar quality performance rather than use arbitrary thresholds based on rankings or predetermined group size. • Multiple grouping factors: K-means clustering and other empirical clustering methods allow for grouping based on multiple factors. While this can make it difficult to interpret the results as the number of factors increase, it also illuminates relationships between the different factors and hospital quality. As CMS evaluates alternative clustering methods, we encourage it to also explore using multiple clustering factors. • Confirmatory analysis of the number of groups: The number of stars in the rating system is set prior to clustering. It would be valuable to understand the natural groupings of scores and whether different ratings reflect differences in quality scores based on statistical methods. • Validity and interpretability: The method selected should produce results that have face validity and are consistent with what is known regarding hospital quality. Further, as the star ratings are public, it is imperative to use methods that can be interpreted and understood by stakeholders. 	Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association	achin@gnyha.org	Hospital Association	Please refer to the Summary Report
3/6/2019	Incorporating Improvement	Yes, CMS should incorporate improvement performance. The intention of CMS Hospital Ratings is to inform consumers of the current status of a institution's quality of care, but also motivates a healthcare organization to improve their quality of care. If an organization actively takes steps to improve their performance, this should be reflected on the website.	Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare	RHyke@stanfordhealthcare.org	Individual	Please refer to the Summary Report
3/14/2019	Incorporating Improvement	They asked about incorporating improvement and whether that would be at the measure level or Star Ratings level. They did not say one way or the other but liked the idea of thinking about rewarding for improvement.	Missouri Hospital Association	(Forwarded by CMS leadership)	Hospital Association	Please refer to the Summary Report

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3/14/2019	Incorporating Improvement	<ul style="list-style-type: none"> Should CMS consider incorporating improvement in future iterations of the Overall Hospital Quality Star Rating? <p>The answer to this question depends on whether the fundamental goal of the Star Rating system is to rate or rank hospitals, or to reward them. If the former, then incorporation of improvement is not useful. The system should focus as clearly as possible on recent, objective performance. If the latter, then incorporation of improvement might be useful, but we agree with the TEP and other stakeholder groups that this is probably not a good idea. The reasons for not going in this direction listed on Page 40 seem convincing to us.</p> <ul style="list-style-type: none"> What are conceptual benefits and risks of incorporating absolute score improvement into the Overall Hospital Quality Star Rating? <p>Although it may be useful in theory to offer some kind of nuanced message about "pretty good and getting better" vs. "pretty good but getting worse" in the Star Rating system, we agree with the TEP and other stakeholder groups that the value of the Star Rating system as a "snapshot" of hospital quality would be diminished by including some measure of improvement.</p> <ul style="list-style-type: none"> How should CMS operationalize this topic? <p>N/A - we don't suggest that this be done at all.</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchu1@hfhs.org	Health System	Please refer to the Summary Report
3/20/2019	Incorporating Improvement	Participants said that giving hospitals credit for improvement was a good idea, this was especially important to those in smaller communities who may only have one or two hospitals nearby. They expressed concern that hospitals developed a bad reputation based on information that may be outdated and that a hospital that has shown improvement either in a category or overall performance should be recognized and rewarded timely.	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	Incorporating Improvement	<ul style="list-style-type: none"> Should CMS consider incorporating improvement in future iterations of the Overall Hospital Quality Star Rating? <p>No. Incorporating improvement adds complexity and does not fully represent current performance. Consumers may not consider a hospital that has improved to be equivalent to those that are already higher performing.</p> <ul style="list-style-type: none"> What are conceptual benefits and risks of incorporating absolute score improvement into the Overall Hospital Quality Star Rating? <p>Improvement is based on comparison to performance during an older period. Incorporating older data into current scoring is a risk.</p>	Jennifer Lamprecht, MS, RN, CNL, CPHQ Director Quality Strategy Sanford Health	Jennifer.Lamprecht@SanfordHealth.org	Health System	Please refer to the Summary Report

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3/21/2019	Incorporating Improvement	On possibility of incorporation of improvement – what happens if a 5-star or 4-star says the same? Do they get a benefit? It seems that a hospital that improves may benefit more from an improvement methodology than a hospital that stays the same and perhaps may not maintain their 5- or 4-star rating because of it.	Hamilton General Hospital	Forwarded by CMS leadership	Hospital	Please refer to the Summary Report
3/22/2019	Incorporating Improvement	This seems premature and we suggest CMS plans to adjust STARS methodology occur prior to consideration of improvement.	Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University	bruce.meyer@jefferson.edu	Health System	Please refer to the Summary Report
3/25/2019	Incorporating Improvement	CMS should not consider a hospital's improvement in comparison to its own prior performance in the methodology. This methodology is currently used in CMS' Value-Based Purchasing Program and provides incentive only to the worst performers. Once improvements are made or if a hospital is a top-performer, outcomes measures “top-out”. Being “worse than the nation” should be incentive enough to drive a hospital to improve.	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/28/2019	Incorporating Improvement	Should CMS consider incorporating improvement in future iterations of the Overall Hospital Quality Star Rating? Yes. If the intent of providing information to health systems and consumers about quality, giving credit for improvement should be rewarded.	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report

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3/28/2019	Incorporating Improvement	<p>Incorporating improvement is a great recommendation as it would incentivize poor performing hospitals to begin improvement. Truly low rated hospitals should be those who have poor performance AND are not trying to improve. Incorporating improvement is also important because many measures have such a long lag time and improving hospitals will be better performers when the stars are ultimately released. Using a similar point system to that in the VBP program would be ideal because it has been used for a number of years already and hospitals have a better sense of the mechanics. This method provides points based on the level of improvement over baseline.</p> <p>We do not agree with the method of averaging in past periods because this actually makes the de facto measurement period much longer which creates disincentives for improving because hospitals would hang on to poor periods longer.</p>	<p>Dr. 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 Chicago, Illinois Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center</p>	<p>Thomas_A_Webb@rush.edu</p>	Medical University	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Advocate Aurora supports the recognition of improvement in the star rating methodology and we recommend CMS consider the use of both improvement (from previous periods) and achievement (compared to national) scores for the measures.	<p>Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health</p>	<p>Shauna.Mccarthy@advocatehealth.com</p>	Health System	Please refer to the Summary Report

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3/29/2019	Incorporating Improvement	Advocate Aurora supports the recognition of improvement (including aligning with Dialysis Facility Compare Star Ratings). Hospitals that incur a negative rating may find it very difficult to gain positive traction in improving star ratings. Incorporating improvement of outcomes into the rating methodology provides a more balanced approach. We recommend CMS consider the use of a both improvement and achievement scores (using the better of the two scores for each hospital) in the star rating methodology.	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Further, we applaud the consideration for incorporating recognition for improvement in outcomes across time into the scoring methodology.	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	3. Incorporate an improvement strategy into the star ratings. This potential change could mimic the hospital VBP program by comparing a hospital's prior performance with the most current data for the refresh. This complicates the scoring but could provide hospitals with a rating that is more reflective of a hospital's improvement strategies and provides a more positive scoring outcome.	Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic	deylingc@ccf.org	Medical University	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Recognizing Improvement: We would recommend that the Overall Quality Hospital Star Ratings continue to focus on hospital attainment in quality and safety. Historically, public ratings have been a snapshot of performance during a particular time period and we believe that model serves patients well.	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	UPH has several reservations about this proposal. First, the Patient & Patient Advocate Work Group raised concerns related to data complexity as well as timeliness. Since patients and consumers are the intended audience, we would give heightened credence to this input. Second, we would want further detail related to how improvement would be weighted within the overall score. We would not support a methodology whereby organizational improvement would inflate overall scores beyond those hospitals who have exhibited steady high-quality performance. If an underperforming hospital reaches average performance, we do not believe that such hospital should be rewarded with an overall score that have exceeds those hospitals with a year-over-year history of above-average performance. Third, we would seek measure details that describe “absolute improvement,” which would distinguish measurable improvement versus standard improvement over time. It would be important to understand how this improvement relates to overall trend.	Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health	cathy.simmons@unitypoint.org	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*
3/29/2019	Incorporating Improvement	Would not recommended...trying to make easy for public. VBP incorporates improvement; possibly using VBP as additional information on Hospital Compare? I remember reading about this possibility somewhere. Maybe consider publishing prior and current star rating?	Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health	kathleencarrothers@gmail.com	Individual	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	LVHN agrees with incorporating improvement scores to the performance score when calculating the Star Rating as is done with VBP.	Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Incorporation of Improvement - YES While the current Overall Hospital Quality Star Rating methodology captures improvement of hospitals in comparison to other hospitals, the methodology currently does not capture a hospital's improvement in comparison to its own prior performance. We do agree that the scoring system should allow points to be obtained for improvement and/or achievement. We support CMS measuring and selecting the higher of the achievement or improvement score. This would mirror how points are awarded in the Value Based Purchasing program.	Holly Wolfe, MBA, Director, Quality & Clinical Improvement, WellSpan Health	hwolfe2@wellspan.org	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	While it is reasonable to incorporate a hospital's improvement into its ratings, the result should not have the effect of penalizing consistent high performers. CMS should consider applying a hold-harmless policy, should the agency decide to incorporate an improvement factor or measure.	Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals	andy.m.amster@kp.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	We do believe that improvement in the primary goal of these rating programs, and that some consideration of improvement is reasonable. However, the structure should be clearly defined so that we recognize that excellent care is more important than improving from poor to average care. One possible operational structure would be to follow the VBP approach which has both absolute and improvement points. However, we would give much greater weight to absolute scores in order to avoid punishing the highest performing hospitals, which have little improvement opportunity.	Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/ University of Michigan	svijan@med.umich.edu	Medical University	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	Incorporating Improvement	Cedars-Sinai does not support incorporating absolute improvement (change) in future iterations of the rating system. The incorporation of improvement adds another layer of complexity onto a methodology that is already complex. It is also would be extremely difficult to operationalize. In addition, Star Ratings should represent a “snapshot” in time and as such, changes in performance would be reflected by changes in a hospital’s Star Rating (and/or Summary Score) over time.	Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center	gail.grant@cshs.org	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Although we think there should be a way to portray to consumers that a hospital’s performance is improving, we agree with the stakeholders groups that having more current data in the Star Rating is more beneficial. Thus improvement cannot be a part of the calculation for Star Rating, but it more appropriate to be on the Hospital Compare site as a feature that consumers can view, if desired to trend from historical periods/star ratings, etc.	Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital	linnea.huinker@northmemorial.com	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	We would like to incorporate the improvement methodology with a rolling average taken into consideration.	Melissa Obuhanick, RN, BS, CPPS, CPHQ, Director of Quality and Risk Management; Grand River Hospital District	mobuhanick@grhd.org	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	<p>5.4. Incorporation of Improvement</p> <p>Should CMS consider incorporating improvement in future iterations of the Overall Hospital Quality Star Rating?</p> <p><input type="checkbox"/> We do not support incorporating 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.</p> <p><input type="checkbox"/> We support refreshing Star Ratings only once annually when all performance data is refreshed. Given the current refresh periods for CMS, this would optimally occur in July of each year.</p> <p>What are conceptual benefits and risks of incorporating absolute score improvement into the Overall Hospital Quality Star Rating?</p> <ul style="list-style-type: none"> We do not feel there is a benefit to using previous data to assign star ratings. The star rating should represent current level of care with the most current data available. The data for most measures already spans 1 to 2 years of performance and lags far behind. 	<p>Jeremy Boal, MD Chief Clinical Officer Executive Vice President Mount Sinai Health System</p> <p>Vicki LoPachin, MD Chief Medical Officer Senior Vice President Mount Sinai Health System</p> <p>G. Troy Tomilonus Vice President, Clinical Decision Support Mount Sinai Health System</p>	troy.tomilonus@mountsinai.org	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*
3/29/2019	Incorporating Improvement	It would be helpful if demonstrated improvement would be noted in the reporting to show a facilities efforts to improve services and quality patient care compared to prior reporting periods	Amy Arnett, MS, RN, CPHQ, CPPS Quality/Infection Prevention Manager Horizon Health	aarnett@myhorizonhealth.org	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	The concept of incorporating bonus points for improvement is deceptive for the overall star rating for a facility. A hospital can improve performance and still have poor performance. Scores should be based on achieving a defined performance threshold, thereby preventing ambiguity.	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Incorporating improvement into the calculation of star ratings would introduce additional complexity into the underlying methodology as well as rely on less-current data. The Joint Commission does not support making the methodology more complicated by incorporating improvement. Instead, the reporting methodology could be enhanced by allowing the display of previous ratings. In addition to avoiding unnecessarily complicated calculations, displaying previous ratings alongside current ratings would more clearly show facilities' improvement to patients and consumers using Hospital Compare. Other methods could be used to improve stability, such as using a more explicit approach to calculating the star ratings. Thank you for the opportunity to review the Quality Star Rating methodology. The Joint Commission encourages CMS' work to refine the rating methodology to produce a precise, understandable rating for patients.	Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission	PRoss@jointcommission.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	CMS requests feedback on various aspects of including improvement in the Overall Hospital Quality Star Ratings. We support incorporating a hospital's performance over time into the Star Ratings methodology.	Peter M. Leibold, Chief Advocacy Officer, Ascension	Danielle.White@ascension.org	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	5.4 Incorporation of Improvement: Star report should be an achievement report and not one that melds previous year's measures i.e. trend improvement. Improvement measures lead to scaling decisions and additional complicated statistics. We suggest that better incorporating physicians/clinicians/hospitalists would lead to organic improvement.	Dale N. Schumacher, MD, MPH, President, Rockburn Institute	dale.schumacher@rockburn.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report

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3/29/2019	Incorporating Improvement	Although we do not support lending previous Star Rating cycles nonzero weight or directly incorporating hospital improvement, we still recognize hospitals' desire for quality improvements to be reflected in future Star Ratings cycles.	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	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.	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	5.Incorporate improvement into the model in order to separate poor performing hospitals who are trying to improve from poor performing hospitals not demonstrating improvement. By incorporating improvement, it would also encourage poor performing hospitals to improve. One Star Hospitals should be those who have poor performance and are failing to demonstrate adequate improvement. An effective example of incorporating improvement into a quality performance program is the CMS Value Based Purchasing Program, which compare outcomes during a performance period with outcomes from a prior base period. We do not support a method that averages outcomes from past periods with more current outcomes because this will simply make measurement periods longer and may actually dilute improvements made during more current periods.	Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health; Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health	Tony.Calabria@Medstar.net	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	My proposed approach can accommodate improvement by incorporating measures of the year-to-year differences. However, I suspect consumers are more likely to select hospitals based on actual performance rather than improvement.	Dan Adelman, Professor, University of Chicago Booth School of Business	Dan.Adelman@chicagobooth.edu	Individual	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	This is an interesting idea and should be incorporated because the purpose of an Overall Hospital Quality Star Rating is to drive sustainable improvement in healthcare nation-wide, but it has the potential to go catastrophically wrong based on the definition of improvement and how it is incorporated. Some of the thoughts we generated for this section are also discussed in Section 2.8. There are three clear ways that this idea could be operationalized in a negative way. Let's go through two examples to illustrate the idea.	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	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*
3/29/2019	Incorporating Improvement	<p>1. Assume Hospital A has 100 patients in Quarter 1 and 100 patients in Quarter 2. Say the rates of performance for a given measure was 63% and 79% during Quarters 1 and 2, respectively. Assume Hospital B has 100 patients in Quarter 1 and 100 patients in Quarter 2. Say the rates of performance for a given measure was 87% and 91% during Quarters 1 and 2, respectively. If total measure improvement was worked into the score, then Hospital A is performing better than Hospital B even though Hospital B was the better performer.</p> <p>2. Assume Hospital has 100 patients in Quarters 1, 2, 3 and 4. Say the rates of performance for a given measure was 63%, 79%, 68% and 62% during Quarters 1, 2, 3 and 4, respectively. Assume Hospital B has 100 patients in Quarters 1, 2, 3 and 4. Say the rates of performance for a given measure was 63%, 79%, 72% and 88% during Quarters 1, 2, 3 and 4, respectively. In Hospital A, we could say improvement happened but that it was not sustained. In Hospital B, we could say improvement has occurred, but to what degree it has occurred is unclear because the process appears to be out of control.</p> <p>There are certainly variations on these examples that should be considered, but these two examples demonstrate things CMS should avoid with the incorporation of improvement. In the first example, you have the potential to punish currently high performing hospitals because there is less room to grow. In the second example, you have three potential issues. First, if the incorporation of improvement is done by asking the binary “Did you improve?”, then the both Hospital A and B deserve full credit for improvement, although one is clearly more effective at sustaining improvement than the other. Second, CMS runs into the potential problems of rewarding unstable process or inconsistent performance if mandatory improvement in six-month or yearly chunks are demanded. Third, CMS could allow hospitals to pick a timeframe that represents best performance, when that timeframe is not illustrative of the surrounding data points (for instance, Hospital A would choose Quarter 2 at 79% for reporting when the actual median of the set is 65.5% and the average is 68%, which is a distortion of the data). Additionally, something like this would have impacts for VBP, MIPS, and HCAHPS, and all of this should be considered prior to any change.</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report

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3/29/2019	Incorporating Improvement	Positive operational implementation would be something like “ improve 2% quarter-over-quarter for at least three quarters”. A definition like this attempts to eliminate pitfalls discussed in the examples above, but there are variations on those examples where a definition like this would not hold. Thus, the definition CMS settles on needs to be well-defined, reliable, and robust in a way that does not marginalize small hospitals like the current star rating does (i.e., smaller/rural hospitals cannot get a rating because their volumes and/or services don’t align with current definitions and processes). One of the suggestions that is given in Section 2.8 is to set a standard, meet the standard, and get a specified score. That methodology would be particularly helpful when it comes to incorporation of improvement and easily incentivizes progress.	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Support the concept as improvement should be incentivized	Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center	deede.wang@vumc.org	Medical University	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Additionally, we recommend CMS consider awarding point/credit based on improvement in a manner similar to the Values Based Purchasing program.	Cathy Wiens, MHA, Vice President/Quality and Compliance; Olathe Medical Center	cathy.wiens@olath.ehealth.org	Hospital	Please refer to the Summary Report

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3/29/2019	Incorporating Improvement	AHPA recommends that hospital improvements be considered in a hospital's star rating. AHPA suggests that this be done through a separate metric within the five-star rating, similar to the method in the Value-Based Purchasing (VBP) program. Both performance against peers and performance against self are both factors currently used in the Value-Based Purchasing (VBP) program. However, AHPA urges CMS to move with caution when selecting a method to integrate previous data into a hospital's summary score for the purpose of demonstrating improvement. Any method adopted should avoid penalizing consistently high performing hospitals for having less room for improvement than a low performing hospital. The benefit of incorporating absolute score improvement is increased information and transparency for patients. The risk is that higher-ranked hospitals may be perceived negatively by patients if they underperform from one year to the next.	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Having a visual indicator for measures that statistically change (for better or worse) from the previous period would be beneficial for the public (basically stop-lighting statistically significant trends) but I don't think there's benefit in incorporating this information into an already complex methodology.	Laura Morris, MS, CPHQ, Senior Business Analyst for Quality	lmorris@glensfalls.hosp.org	Individual	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Incorporating improvement is a great recommendation as it would incentivize poor performing hospitals to work toward improvement. Using a point system similar to that in the value based purchasing program would be ideal as it has been validated over time, is reliable, and hospitals are familiar with its mechanics.	Jean Cherry, FACHE, Executive Vice President, Med Center Health	jean.cherry@mchealth.net	Healthcare System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	Given the variability in scores generated using the latent variable modeling, the inclusion of an improvement score would not be helpful at this time. Additionally, Vizient believes that adding an improvement score would inherently introduce older data into the scoring, hurting the timeliness of the score. Thus, Vizient does not recommend including an improvement score, as doing so may lessen the impact of current performance.	Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.	Chelsea.arnone@vizientinc.com	Healthcare performance improvement company	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	While MGH appreciates the value that could be added from including measure improvements, overlapping reporting periods could blur any true improvement and would add a potentially unnecessary layer of complexity to the methodology. Therefore, at this time MGH would not endorse the incorporation of measure improvement from the previous rating period unless further details are provided.	Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital	emort@partners.org	Medical University	Please refer to the Summary Report

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3/29/2019	Incorporating Improvement	The FAH does not support incorporation of hospital-specific improvement into Star Ratings. If a hospital's star rating changes from a previous period, it will either be rewarded or disadvantaged by the new rating. There is no need to explicitly include the change in calculating the rating. Public reporting of an indicator of directionality of change would contribute to consumer confusion and may not be meaningful information. As noted above, a change in one year may not be predictive of current or future performance.	Chip Kahn, President, CEO, Federation of American Hospitals	csalzberg@fah.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	As CMS considers the incorporation of improvement into future considerations of the Overall Hospital Quality Star Rating methodology, we do not support methods that bridge performance over two years to "smooth" year over year changes. We would recommend an approach that weights domains in the star rating (i.e., mortality, readmissions vs. HACs and Patient Experience) and reflects placing more weight on groups with data that are more current such as HACs/infections and Patient Experience. Outdated data do not provide an adequate snapshot of current performance for the public and may inhibit quality improvement for the hospital itself. We believe this is the best way to incorporate improvement.	George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health	George.t.blike@hitchock.org	Healthcare System	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	The concerns of consumers should be paramount; they care about current, on-the-ground quality, not recent improvements nor past information. Incorporating recent improvement would also disadvantage hospitals already performing well.	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	Please refer to the Summary Report
3/29/2019	Incorporating Improvement	While the current Overall Hospital Quality Star Rating methodology captures improvement of hospitals in comparison to other hospitals, the methodology currently does not capture a hospital's improvement in comparison to its own prior performance. For example, CMS could average the hospital summary score from two different time periods by combining 50% of the prior reporting period with 50% of the current reporting period or 25% of the prior period with 75% of the current period. We believe year over year improvement represents targeted quality improvement efforts and should be a part of the rating.	Leslie M. Jurecko MD, MBA SVP, Quality, Safety, and Experience Spectrum Health Pediatric Hospitalist Assistant Professor of Pediatrics at Michigan State University, College of Human Medicine	Leslie.Jurecko@spectrumhealth.org	Hospital	Please refer to the Summary Report

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2/28/2019	User-Customized Star Rating	We also believe the time has arrived for 21st century methods to measure quality care. Tremendous progress in the use of electronic data has enabled high quality information to be captured by our electronic record systems. Patient access to data has similarly been transformed through the use of standards, like FHIR, and inclusion of these data in our mobile devices like the iPhone. Patients deserve high quality methods that are not one-size-fits-all, and are personalized and precise. The next evolution of measurement should be accurate and personalized which guides patients to the best care possible. The science behind ranking hospitals and providers of one versus the other is complicated. We are hopeful that those doing these rankings listen to the medical community when information is provided and misleading findings can be held. Without correcting for the factors described above, releasing Stars could very well have a detrimental effect on both providers and consumers.	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	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report
3/6/2019	User-Customized Star Rating	Definitely add customization. Again, the intention is to provide consumers the current state of quality performance. They should be able to adjust it to their needs.	Roxanne R. Hyke RN, BS, MSN, Director: Quality Reporting, Sanford Healthcare	RHyke@stanfordhealthcare.org	Individual	Please refer to the Summary Report
3/14/2019	User-Customized Star Rating	They liked the idea of a consumer defined criteria which they found would be useful to patients.	Missouri Hospital Association	(Forwarded by CMS leadership)	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*
3/14/2019	User-Customized Star Rating	<ul style="list-style-type: none"> Should CMS consider introducing user-customization to the Overall Hospital Quality Star Rating? <p>In general, this is a good and useful idea, but we would suggest that CMS take the concept and move it one or two steps further. Given that a global Star Rating exists and can be seen by a consumer, the most useful customization we can think of for a consumer would start by allowing the consumer to first choose the clinical condition (e.g., elective hip replacement) that he or she was interested in, and then choose from among those measures that relate to that condition. For example, Comp-Hip-Knee would be relevant (actually, Comp-Hip would be more relevant) and HAI-3 and HAI-4 would not be relevant. The consumer could choose just those measures he/she cares about (e.g., infection vs. mortality vs. readmission vs. pressure ulcer). or there could be a weighting system as illustrated in Table 15 to create some kind of composite score. In this kind of a system, the consumer would see one Star Rating and then move past that to see the specific measures most relevant to his/her clinical condition(s) and areas of concern. The method would not produce a tailored Star Rating at all - it would produce focused, relevant information on the specific quality measures that might possibly be predictive of the patient's own future experience.</p> <ul style="list-style-type: none"> What is the usability, utility, and validity of such a tool? <p>{See response immediately below}</p> <ul style="list-style-type: none"> What are potential benefits and drawbacks to such a tool? <p>HFHS is not confident that a customized Star Rating like that illustrated in the Request document would be useful. It maintains most of the problems of the current system - basically that a patient interested in predicting his/her future experience with a specific clinical condition ends up with a blend (even a tailored blend) of relevant and irrelevant measures, rather than a set of clearly-relevant measures drawn from the larger pool of those available in Hospital Compare.</p> <ul style="list-style-type: none"> How could CMS incorporate such a tool into the existing Overall Hospital Quality Star Rating methodology? <p>As noted just above, we do not feel that a customized Star Rating tool as described in the Request document would be particularly valuable. We would suggest that CMS focus on the other areas of improvement that have been discussed earlier.</p>	Betty Chu, MD, MBA, Associate Chief Clinical Officer and Chief Quality Officer, Henry Ford Health System	bchul@hfhs.org	Health System	Please refer to the Summary Report

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3/21/2019	User-Customized Star Rating	<ul style="list-style-type: none"> Should CMS consider introducing user-customization to the Overall Hospital Quality Star Rating? <p>No. This is an innovative idea, but is confusing and burdensome for the end user.</p> <ul style="list-style-type: none"> What is the usability, utility, and validity of such a tool? <p>It would be simpler for consumers to see a separate star rating for each measure group, but this does not meet the purpose of an overall rating. Star ratings could be calculated for each group in addition to the overall star rating.</p> <ul style="list-style-type: none"> What are potential benefits and drawbacks to such a tool? <p>Some users might like the interactive tool, but most may find it confusing.</p>	Jennifer Lamprecht, MS, RN, CNL, CPHQ Director Quality Strategy Sanford Health	Jennifer.Lamprecht@SanfordHealth.org	Health System	Please refer to the Summary Report
3/21/2019	User-Customized Star Rating	OHSU would recommend putting efforts into revising the Star Rating methodology to create a more consistent and accurate ranking before putting resources into a User-Customized platform. The idea is intriguing but it assumes that consumers are well-versed in the domains and individual measures and that the measures reflect what consumers truly care about. In addition, hospitals would not receive standardized feedback on what consumers want if the ratings could be customized.	Elana Zuber, MBA, Quality Management System Program Manager, Oregon Health and Science University	matere@ohsu.edu	Medical University	Please refer to the Summary Report
3/22/2019	User-Customized Star Rating	<p>This is an interesting idea as value depends on execution, web interface and ease of use for consumers. We believe this is worth exploring and suggests that an overall score may not serve consumers well.</p> <p>To conclude, we thank you again for the opportunity to provide feedback on future considerations for the Stars Rating Program. We appreciate CMS' ongoing efforts to improve quality and to ensure transparency.</p>	Bruce A. Meyer, MD, MBA, President, Jefferson Health; Senior Executive Vice President, Thomas Jefferson University	bruce.meyer@jefferson.edu	Health System	Please refer to the Summary Report
3/25/2019	User-Customized Star Rating	<p>I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration.</p> <p>User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.</p>	Alison L. Hong, MD, Chief Quality Officer, St Peter's Health Partners	Alison.Hong@trinity-health.org	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*
3/25/2019	User-Customized Star Rating	For the future, CMS should further explore the concept of a simplified User-Customized Star Rating.	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/25/2019	User-Customized Star Rating	BHS also recognizes that the determination of the weightings of each measure group may not reflect the values and preferences of consumers. The idea of developing a User-Customized Star Rating tool where the consumer can change the weightings of the groups based on his/her preferences, is interesting but not of meaningful value to the general public. I do not believe that all of the measures groups resonate, or are even understandable to the general consumer. For example, “Readmissions” “Safety of Care” and “Effectiveness of Care” are extremely broad categories that you need to dive into on the Compare site to see what is actually measured within the group. And in many instances, there is ongoing debate by stakeholders as to whether the measures truly reflect quality (i.e. PSI-90 Composite). A reasonable next step would be to assign a 1-3-5 star rating to each of the measure groups, and then issue an Overall 1-3-5 Star Rating. This would be similar to the current HCAHPS model of assigning a star rating to each of the 10 HCAHPS groups as well as an HCAHPS Summary Star Rating. This change would begin to better introduce consumers to the complexity and variables involved in assessing a hospital’s “quality”.	Julie Wall, RN, MBA, FACMPE, System Vice-President, Quality & Patient Safety Benefis Health System	juliewall@benefis.org	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*
3/25/2019	User-Customized Star Rating	<p>Recommendation #3 – CMS should take a common-sense approach to making published Star Ratings more valuable to consumers. Benefis shares CMS’ desire to ensure that public ratings are consumer-friendly. However, current considerations to develop a User-Customized Star Rating Tool through which consumers visiting the Hospital Compare website could change the weightings of measure groups based on their preferences would not facilitate consumer usability. The average consumer does not understand the meaning of some of the individual measure groups, nor do they know what is quantified within the measure groups, and in many cases stakeholders continue to debate whether the measures truly even reflect quality.</p> <p>As an alternative to developing a User-Customized Star Rating Tool, Benefis believes a reasonable next step is to expand from publishing just the aggregate Star Rating to also publishing ratings for each measure group in order to begin to introduce consumers to the complexity and variables involved in assessing a hospital’s “quality”.</p>	Greg Tierney, MD, Chief Medical Officer and Medical Group President, Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report
3/26/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Sharon Johnson, MBA, CPHQ, CPPS, Director of Quality Management, Utilization Management and Patient Safety; Highland Hospital of Rochester	Sharon_Johnson@URMC.Rochester.edu	Individual	Please refer to the Summary Report
3/26/2019	User-Customized Star Rating	I am also concerned about user-defined star ratings. This is going to make an already complex scoring system more complex and confusing. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings. Remember restaurant and hotel rating systems are effective because they are simple.	Pat Reagan Webster, PhD CPPS, Associate Quality Officer; Strong Memorial Hospital; Associate Professor, Public Health Sciences; University of Rochester	patricia_reagan@urmc.rochester.edu	Individual	Please refer to the Summary Report

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3/26/2019	User-Customized Star Rating	The ability for end user to customize weighting to what is most important is a very good idea.	Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital, Quality Management Dept.	scrimet@amc.edu	Individual	Please refer to the Summary Report
3/26/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Michele Walsh, MSN, RN, CNO; Ascension	Michele.Walsh@ascension.org	Individual	Please refer to the Summary Report
3/26/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, increasing subjectivity and will make the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Kathy Parrinello PhD, Executive Vice President and COO; Strong Memorial Hospital, University of Rochester Medical Center	Kathy_Parrinello@URMC.Rochester.edu	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Daniel J. Baker, MD, MBA, Medical Director, Lenox Hill Hospital	djbaker@northwell.edu	Individual	Please refer to the Summary Report

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3/27/2019	User-Customized Star Rating	<p>Usefulness to Consumers: The ratings should provide information that is relevant to the wide range of reasons patients seek hospital care, and give consumers the ability to drill down on the particular aspects of care most relevant to them. As currently designed, we are concerned that star ratings do not reflect the aspects of care most relevant to a particular patient's needs. For example, a family may be interested in selecting the best hospital for cancer care, but there are no such measures included in the current star ratings</p> <p>Topic-specific star ratings. The AHA 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. For example, a family may be interested in selecting the best hospital for cancer care, but there are no such measures included in the current star ratings. That is why the AHA 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.</p>	Ashley Thompson, Senior Vice President, Public Policy and Policy Development, American Hospital Association	ademehin@aha.org	Hospital Association	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Karen Carey, Interfaith Medical Center	KCarey@INTERFAITHMEDICAL.org	Individual	Please refer to the Summary Report

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3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Kim Clement, Quality Analysis	kclement@cmhhamilton.com	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Sean Fadale, FACHE President and CEO Community Memorial Hospital	SFadale@Seancmhhamilton.com	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. I recommend not moving forward with the consumer-customized ratings.	Beth Falder, Health Quest	bfalder@Healthquest.org	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Kathleen M Hebdon, MSN, RN, CDE	KHebdon@bch-jbr.org	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Amir K. Jaffer, MD, MBA Chief Medical Officer, New York Presbyterian Queens Hospital	ajaffer@nyp.org	Individual	Please refer to the Summary Report

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3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Kurt Kodroff	KKodroff@kingsbrook.org	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Jacquel Kouns, MS, RN, NEA-BC, FACHE Executive Director - Montefiore Mount Vernon Vice President of Clinical Services	JKOUNS@montefiore.org	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	LuAnne Roberts	lroberts@wcchs.net	Individual	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	UC Health expresses concern with CMS's proposal to create a tool that would allow consumers to devise their own user-customized Star Ratings. It is a laudable goal to be transparent with consumers about the measures by which hospitals are evaluated. We know there are many factors that consumers consider when assessing which hospital they consider best to deliver their care, or that of a family member. Each individual patient's diagnosis and circumstances are different, thereby sometimes necessitating care not evident in the measures evaluated to produce an individual hospital's Star Rating. Because each patient's medical care needs vary, we must expect variation in the measures that matter to each patient. A hospital's Star Rating can fail to capture the hospital's expertise in a given area of care, and that area of care may be what is most critical to a given patient.	John Stobo, MD, Executive Vice President, University of California Health System	Julie.Clements@ucdavis.edu	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*
3/27/2019	User-Customized Star Rating	<p>User-Customized Star Rating: CMS is seeking input about: whether it should consider introducing a user-customized tool; the usability, utility, and value of such a tool; as well as the benefits and drawbacks.</p> <p>While we applaud CMS for exploring a user-centered approach to customize the star ratings based on what is important to the patient, we are concerned that it could potentially mislead the general public due to their lack of specialized healthcare knowledge. In addition, we do not believe there are enough patient reported outcome measures that truly reflect what is important to patients for example, when they will gain mobility after a total knee operation. The other issue is the fact that the results are based on the Medicare population on a limited number of medical conditions or procedures. Even in the case of a patient 65 years old or older using the custom interface, if they are going to have a procedure to repair a tear in their rotator cuff, how useful is the star rating results in directing them to the best facility. While we do not discourage CMS from pursuing innovative ways for the general public to use the star ratings, we urge caution to not create unintended consequences from misinterpreting the results especially for the non-Medicare general public.</p>	Angela A. Shippy, MD, FACP, FHM SVP & Chief Quality Officer Memorial Hermann Health System	Angela.Shippy@memorialhermann.org	Health System	Please refer to the Summary Report
3/27/2019	User-Customized Star Rating	MHA acknowledges the potential consumer benefit of introducing user-customization features to the Overall Star Rating and suggests further exploration with an intensive focus on measurement validity as well as usability from the consumer perspective. From a methodologic perspective, we would recommend serious pursuit of this concept only after serious methodologic concerns with Star Ratings dimensional measures and grouping are substantively and satisfactorily addressed to mitigate potential confusion among users and providers. From a usability perspective, MHA's experience has shown that the importance of end-user feedback and user-experience-based design principles cannot be overstated when developing sophisticated user self-service features. We look forward to hearing more about further development of this concept and hope to have the opportunity to provide substantive feedback as development takes shape.	Herb B. Kuhn, President, CEO, Missouri Hospital Association	DLandon@mhanet.com	Hospital Association	Please refer to the Summary Report

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3/28/2019	User-Customized Star Rating	<p>User-Customized Star Rating: The AAMC is supportive of exploring user-customization to the Star Ratings, but believes additional investigation and analysis is needed to better understand patient and consumer interest and to ensure that customized ratings are reliable and valid.</p> <p>User-Customized Star Rating</p> <p>Currently the Star Ratings are based upon fixed measure group weights, representing a generalized vision of aspects of quality that are important to measure, while allowing hospitals to be compared against each other under a common rubric. These group weights, however, may not capture priorities, preferences, or values of an individual patient or consumer. CMS seeks feedback on whether to further explore the introduction of a user-customization tool to the Overall Hospital Quality Star Rating, and on how to build and implement such a tool.</p> <p>The AAMC agrees that the Overall Hospital Quality Star Ratings must be meaningful to patients and consumers. We agree that a customizable ratings tool conceptually might create greater alignment with the consumer focus of the Ratings. CMS discusses a single measure group weight customization concept as one way to generate user-customized Star Ratings.</p> <p>The measure group weight customization concept described appears to follow the work by the RAND Corporation with its Personalized Hospital Performance Card.¹⁰ Under RAND’s concept, a user can see the difference among hospitals’ Star Ratings under the prescribed measure group weightings. The user also can manipulate those group weightings. For example, a user could determine she only cares about mortality, and re-weights mortality 100% of the Rating, and compare that result to CMS’s Rating. This gives users the ability to see CMS’s Rating, while also, if they should so choose, incorporating their own values and preferences.</p> <p>If CMS were to implement something similar to RAND’s concept, the AAMC asks CMS to clarify how it would adjust the customized Ratings for a hospital where the hospital does not have a measure group score for a group a user has increased the weight to. In such a case, would CMS’s tool recalibrate to give those weights to</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report

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3/28/2019	User-Customized Star Rating	<p>other groups included by the user? Or would it result in a “not applicable” response to alert the user that the hospital is unable to be measured on that user’s criteria? Another customization concept CMS could consider is one based upon condition. This would be a significantly bigger project to implement, as CMS would need to assess which conditions could be “singled” out with a rating with sufficient measures, and whether the condition-specific ratings are valid and reliable. Given the complexities of implementing this type of customization, the AAMC puts it forth only as a potential area to explore for the future as this may be the most meaningful type of information for many patients and consumers.</p> <p>Generally, the AAMC is supportive of exploring user-customization to the Overall Hospital Quality Star Ratings. However, we believe more investigation is needed to better understand patient and consumer interest in and understanding of the concept to ensure that any tool meets their needs and is not overly burdensome or complex. Additionally, customized ratings must be reliable and valid before a customization tool is released to the public.</p> <p>10 See RAND Corporation “Personalized Hospital Performance Card” available at: https://www.rand.org/health-care/projects/personalized-hospital-performance-report-card.html (Visited March 25, 2019).</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report
3/28/2019	User-Customized Star Rating	However, we are not in favor of user-customized star ratings.	Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital; Henry Pitt, MD, Chief Quality Officer, Temple University Health System	henry.pitt@tuhs.temple.edu	Health System	Please refer to the Summary Report

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3/28/2019	User-Customized Star Rating	<p>5.5 User-Customized Star Rating</p> <p>Questions for the Public:</p> <p>Should CMS consider introducing user-customization to the Overall Hospital Quality Star Rating?, Giving the consumer the ability to customize and determine scores based on what's important to the patient could certainly provide value, however the metrics must be understandable and designed around what is important to the consumer. Current metrics used do not consistently meet this definition</p> <p>What is the usability, utility, and validity of such a tool? Until the metrics are designed to be more consumer facing and less directed by what is available in claims data, I am not sure that many people will use the feature.</p> <p>What are potential benefits and drawbacks to such a tool? Consumers would need a lot of education about the measures and scores. Again, if the measures are not easy to understand and consumer facing, this tool will not be of value.</p> <p>How could CMS incorporate such a tool into the existing Overall Hospital Quality Star Rating methodology? This should not be incorporated into the overall star rating. If developed, this should be a separate tool overlying the same data set.</p>	Mark Browne, MD, MMM, CPE, FACPE; Senior Vice President / Chief Medical Officer; Covenant Health	mbrowne@covhlth.com	Health System	Please refer to the Summary Report

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3/28/2019	User-Customized Star Rating	<p>We strongly endorse this approach. A user customization tool similar to what has been produced by the RAND corporation (https://www.rand.org/health-care/projects/personalized-hospital-performance-report-card.html) would be helpful to patients/consumers and allow them to see changes based on their interests. Certainly some expectation setting and education about the use of a tool would be needed. If this was introduced in addition to the other proposed changes (less reliance on the latent variable model, standard and transparent weighting of domains, and modified adjustment based on size) that will help to show value. A risk of this approach is the lack of a single measure for a hospital – however, we feel that this is outweighed by gains based on more clarity around these measures. A strategy for the roll out of a tool like this would be to have multiple weights based on consumer profiles or patient stories. For example, a healthy first time patient with an elective procedure might have one set of weights, while a patient with a chronic disease might have a different set of weights. These could be explicitly modeled and provided as examples by CMS.</p>	<p>Dr. 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 Chicago, Illinois; Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine; Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center</p>	<p>Thomas_A_Webb@rush.edu</p>	Medical University	Please refer to the Summary Report

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3/29/2019	User-Customized Star Rating	CMS is considering creating a user-customized Star Rating tool. Currently, the weights of each measure group are fixed (22% for each outcome group, 22% for patient experience, and 4% for each of the process measure groups), and this fixed approach may not reflect the values and preferences of patients and consumers. A user-customized approach would allow patients and consumers to express their preferences by setting the contribution or weight of each of the measure groups in the calculation of the hospital summary score and calculating star ratings for every hospital personalized to the user's values. Allowing beneficiaries the opportunity to customize their searches based on specific needs would be a positive for patients. This could include a roll up of the patient's top 3 to 5 needs/desires, which then reflects an average star rating.	Leslie M. Jurecko MD, MBA SVP, Quality, Safety, and Experience Spectrum Health Pediatric Hospitalist Assistant Professor of Pediatrics at Michigan State University, College of Human Medicine	Leslie.Jurecko@spectrumhealth.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Sameh Samy, MBBCh, MSA, CPHQ, AVP, Quality Management Dept., Maimonides Medical Center	APollack@maimonidesmed.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	The proposal to allow consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We know experientially, that for the majority of our patients and families this is a false assumption. We recommend not moving forward with the consumer-customized ratings.	William Lynch, Executive Vice President and Chief Operating Officer, Jamaica Hospital Medical Center	BFLANZ@jhmc.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	I am writing to register my concerns with the CMS Overall Hospital Quality Star Ratings and the proposals under consideration. User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Sharon L. Narducci DNP, APRN-BC, CCRN, Chief Quality Officer, Jamaica Hospital Medical Center, Flushing Hospital Medical Center	SNARDUCC@jhmc.org	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*
3/29/2019	User-Customized Star Rating	5c. User-Customized Star Rating: Advocate Aurora has strong concerns about providing a tool that would allow users to hand-pick measures or groups of measures to calculate one personalized star rating and recommends further analyses by CMS of this tool.	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Advocate Aurora has strong concerns about providing a tool that would allow users to hand-pick measures or groups of measures to calculate one personalized star rating. CMS does not have measures for all conditions a patient may be assessing and as a result, consumers may not choose metrics that fully define the care they are looking to evaluate. This could result in unintended inaccurate overall ratings used by consumers in choices for care. Any such tool should more simply provide measure-level ratings without rolling them up to an ill-defined personalized star rating.	Gary Stuck, DO FAAFP, Chief Medical Officer; Advocate Aurora Health	Shauna.Mccarthy@advocatehealth.com	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	4. Development of a star rating tool that would generate “user-defined” star ratings based on what is most important to an individual user. The relevance of this potential future change is based on the premise that consumers understand the measure and how it is defined and have a basic understanding of the clinical importance of a measure in making future care decisions. It is clear that the general public is starting to use the data from raters and rankers and that they are becoming more literate in understanding measures. It also may have some adverse consequences for some hospitals that may not do as well in a single measure, such as a readmission measure, but overall have a 5-star rating. To inform the public more fully it may be useful to provide an overall star rating while also allowing a consumer to compare hospitals based on a subset of measures that are of particular importance. We would recommend that as this potential change is developed, a diverse group of stakeholders be included in the development and testing.	Cynthia Deyling, MD, MHCM, FACP, Chief Quality Officer; Cleveland Clinic	deylingc@ccf.org	Medical University	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Creation of a User-Customized Tool: While we question the usefulness of a single composite score for patients, as we move toward precision in medicine, the idea of users being able to customize the relative weights to match their values and preferences aligns with that direction. We would recommend the CMS pilot test a user-customized star rating tool to see if patients find it of any additional value.	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report

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3/29/2019	User-Customized Star Rating	<p>User-customized star ratings would allow Hospital Compare users to interactively set the weights of measure groups that are used to calculate hospital summary scores and display clustered ratings based on those customized summary scores. This would allow users to prioritize domains of care that are more important to them and compare hospitals by that preference. The tool could provide a set of predetermined default weights as a starting point for users who do not want to set their own weights. Also, due to computational limitations, a limited number of possible combinations of group weight would be available.</p> <p>Enabling consumers to create their own customized Star Ratings using a three-point scale would cause major rating swings, making the rating system more confusing for consumers, not less. As shown in the graphic below, if users were to select different preferences than CMS' baseline modeling, several providers would change Star Ratings classifications with some lower-rated hospitals moving to the highest rating categories. [Figure 7]</p> <p>The graphic above estimates provider classifications using high preference toward mortality of care, effectiveness of care and medical imaging efficiency with low preference/weight toward all other domains. HANYS estimates nearly 60% of providers would change Star Ratings in this scenario.</p> <p>This proposed customization assumes that patients and families possess the clinical and statistical knowledge, and the time needed to decode the Star Ratings to decide what is most relevant to them. HANYS recommends not moving forward with the consumer-customized ratings.</p>	Marie Grause, RN, JD, President, Healthcare Association of New York State	lwillis@hanys.org	Marie Grause, RN, JD, President, Healthcare Association of New York State	Please refer to the Summary Report

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3/29/2019	User-Customized Star Rating	<p>We believe that healthcare decisions are intimate and reflect the preferences and needs of patients and their families/caregivers. While we believe that consumers should factor in quality and safety considerations when making healthcare choices, we also recognize that many consumers value other factors outside these measures. From the consumer perspective, a look-up tool that enables consumers to incorporate healthcare and other preferences would be meaningful if such tool contains complete and accurate data and includes information beyond quality. UPH would support the development of a CMS decision support tool for consumers; however, this user-customized tool is different and distinct from a customized Star Ratings tool, which we do not support.</p> <p>The inherent value of any Star Ratings system is its standardized rating process. The Overall Hospital Quality Star Rating is restricted to quality and safety measures selected by CMS and targeting Medicare patients. Through user customization which relies on data manipulation, standard ratings will be lost and the tool will require data literacy efforts so that consumers understand their results. We believe that there is vast potential in a look-up tool that loads consumer preferences, but we envision this as a separate tool from the Star Ratings system.</p>	Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health; Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health	cathy.simmons@unitypoint.org	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	CMS should consider a rating system that is customized based on an individual patient needs. The current Hospital star rating system is generalized, and the general ratings fail to capture a hospitals expertise in an area of care most important to a patient.	Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital	johnrothenberger@tgh.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Daniel Lombardi, DO, MBA, FACOEP, VP/Chief Quality Officer, Associate Medical Director, St. Barnabas Hospital Health System	dlombardi@sbhny.org	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*
3/29/2019	User-Customized Star Rating	As for the proposed changes to the current ratings system, Richmond University Medical Center takes the following positions: User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center	ALutz@RUMCSI.org	Medical University	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Cheryl Feeman Macafee, MBA, CPHQ, RHIA, Director of Quality Management	MacafeeC@jmhny.org	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Wendy Blakemore MS, BSMT (ASCP), Director of Quality, Patient Safety and Utilization Management, Thompson Health	Wendy.Blakemore@thompsonhealth.org	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Karen Bonilla, Senior Governmental Affairs Specialist, PAC Manager at Healthcare Association of New York State	KBonilla@hanys.org	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Finally, we think allowing consumers to create their own customized star ratings will obfuscate and be confusing. Making yet, another Leapfrog-type tool pushes responsibility on unprepared and ill equipped consumers to interpret ratings. For the reasons stated above, we recommend not moving forward with the consumer-customized ratings.	Ronette Wiley, Executive Vice President & Chief Operating Officer, Bassett Medical Center	jackelyn.fleury@basset.org	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*
3/29/2019	User-Customized Star Rating	Believe this would be too arbitrary results in many different interpretations. Users can already compare each measure group and if they are interested in a specific group, they already have that information.	Kathleen M. Carrothers, MS, MPH, Data and Improvement Strategist, Cynosure Health	kathleencarrothers@gmail.com	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allowing consumers to choose what they feel is important but the consumer may not understand fully understand the measure definitions. Also, the measures available may not directly reflect the concerns of the individual consumer. The calculator is limited to certain medical conditions and well as consumers age 65 or older. The approach would not allow for a fair comparison between hospitals. LVHN is supportive of exploring user-customization to the Star Ratings, but believes additional investigation and analysis is needed to better understand patient and consumer interest and to ensure that customized ratings are reliable and valid.	Matthew McCambridge, M.D. MS, FACP, FCCP, SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	User-Customized Star Rating – No CMS is considering creating a user-customized Star Rating tool. We do not support a user-customized star rating. This approach would be extremely difficult for hospitals to manage and would negatively impact our ability to respond to patients (patient populations , clinical diagnostic groupings and outcomes). We strongly disagree with the idea of user-customized star ratings.	Holly Wolfe, MBA, Director, Quality & Clinical Improvement, WellSpan Health	hwolfe2@wellspan.org	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	We are not in favor of user-customization for the rating unless much more work is done to understand consumer preferences and to create a clear method of communicating the meaning of the result. It would not be unreasonable to consider a more nuanced (e.g., 1-5 star rating) for each group, instead of current three categories of Above, Same or Below the national average. Customers could then use their own judgement to decide on which quality group is of the most importance to them.	Sandeep Vijan, MD, MS, Professor of Internal Medicine, Medical Director of Quality Analytics, Assoc. Division Chief, General Internal Medicine; Michigan Medicine/University of Michigan	svijan@med.umich.edu	Medical University	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	User-Customized Star Rating	The public input request describes a user-customized approach that would allow patients and consumers to express their preferences by setting the contribution or weight of each of the measure groups in the calculation of the hospital summary score and calculating star ratings for every hospital personalized to the user's values. This is an intriguing concept, which we would generally support. We support the use of tools that allow sophisticated consumers and purchasers to fine-tune the relative importance of quality, safety, efficiency and care experience categories for their needs when interpreting these data. We note, however, overall use may be rare and may not significantly affect individuals' decisions on where to seek care, and much of these data (e.g. HCAHPS) are already currently available to consumers on Hospital Compare in disaggregated form. Should CMS pursue such an approach, it is again important that the usability and navigability of the system be thoroughly tested and available for public comment before implementation.	Patrick Courneya, M.D., Executive Vice President and Chief Medical Officer; Kaiser Foundation Health Plan and Hospitals	andy.m.amster@kp.org	Hospital Association	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Cedars-Sinai's assessment of this proposal is that the development of such a customized star rating at this time is premature. However, as the Star Rating methodology is improved, and the population becomes more digitally oriented, such an approach may be have increasing appeal and usefulness. It could be developed at a future time.	Gail P Grant, MD, MPH, MBA, Director, Clinical Quality Information Services; Cedars-Sinai Medical Center	gail.grant@cshs.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Lastly we agree since this is a public tool for healthcare decision making that, user-customized star rating would be a nice feature for the public.	Melissa Obuhanick, RN, BS, CPPS, CPHQ, Director of Quality and Risk Management; Grand River Hospital District	mobuhanick@grhd.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Allow users to see updated ratings results based on the user's inputs for measure group weightings as based upon the individual user's values. This should be the vision of the program to drive care delivery choice through precision based on user-customizable ratings. The current measure group weights are fixed. These group weights are likely not capturing priorities, preferences, or values of an individual consumer. More investigation is needed to understand consumer interest and understanding of the user-customized tool.	Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital	seamus.b.dolan@healthpartners.com	Hospital	Please refer to the Summary Report

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3/29/2019	User-customized Star Rating	We do not fully support the user customizable tool for Star Ratings as it would be complex and confusing for consumers. Also, if they are only interested in a subsection of the Star Ratings and are curious of performance, this is the existing and initial purpose of the Hospital Compare site to see current performance and if they are below, above or the same as national average.	Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital	linnea.huinker@northmemorial.com	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Once CMS develops a fair and reliable Star Rating, we support the development of a User-Customized Star Rating to allow patients to prioritize what aspects of quality are most important to them as they seek care at particular hospitals. Without a more reliable methodology, allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance	Jeremy Boal, MD, Chief Clinical Officer, Executive Vice President, Mount Sinai Health System; Vicki LoPachin, MD , Chief Medical Officer, Senior Vice President, Mount Sinai Health System; G. Troy Tomilonus, Vice President, Clinical Decision Support, Mount Sinai Health System	troy.tomilonus@mountsinai.org	Hospital	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	User-defined star ratings: Allowing consumers to create their own customized star ratings will cause major ratings swings, making the system more confusing for consumers, not less. This proposal assumes that patients and families possess the clinical and statistical knowledge, and the time needed, to decode the ratings and understand their relevance. We recommend not moving forward with the consumer-customized ratings.	Kathleen R. Reilly, B.S., RRT, CCMSCP Director, Quality and Performance Improvement Finger Lakes Health (Geneva General Hospital/Soldiers and Sailors Memorial Hospital)	Kathleen.Reilly@fingerlakeshealth.org	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*
3/29/2019	User-Customized Star Rating	Strongly opposes any approach to scoring hospitals on individual measures selected by patients to develop their own rating of a hospital. While conceptually we agree it seems the most consumer-friendly and obvious choice, the complexity of such an approach and opportunity for misleading information to be provided give us great pause.	Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association	nhoffman@calhospital.org	Hospital Association	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	The stated goal of the Hospital Compare methodology is to provide consumers with a simple overall rating to help guide their decision on where to receive care ⁴ . Implicit in this directive is that the target audience - the “typical” American consumer – benefits because of the simplicity of the rating system. Given that very highly-educated academics and clinicians continue to debate over the complex methodology employed by CMS in calculating these ratings ^{2,7} , we believe the consumer will continue to benefit from a simple, composite score approach rather than transferring greater responsibility onto the consumer requiring them to understand additional mathematical complexities. In fact, for more advanced consumers who desire in- depth analysis, Hospital Compare already displays performance by measure group (mortality, patient experience, etc.) to further distinguish hospitals in the area(s) which may be of greater particular interest to a specific consumer. To illustrate how a customizable approach might lead to confusion, imagine a consumer using a customizable tool to select a hospital for an elective percutaneous coronary intervention (PCI) – a procedure with a mortality of well below 1% ⁸ . Given this procedure is relatively safe, an anxious consumer might over-weight mortality (comparing a hospital with mortality of 0.2% versus 0.4%) in a customizable tool despite the minimal absolute risk difference. In this case, the differential PCI quality care between hospitals is more likely to be evidenced by differences in patient experience and safety. On the other hand, a consumer needing to select a hospital for a higher-risk aortic valve replacement (AVR) procedure might unknowingly underestimate the importance of mortality – in this case they might fail to adequately distinguish the difference between a hospital with a 5% versus 10% mortality risk ⁹ , which should be at the forefront of a consumer’s mind for such high-risk procedures. Because academics and clinicians continue to debate and refine the weighting of different quality metrics, it is unfair and potentially unsafe to push this responsibility onto the consumer without a much more thorough assessment of the risks and benefits.	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	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*
3/29/2019	User-Customized Star Rating	<p>2. Castellucci M. CMS hospital star-rating system has been wrong for two years, health system finds. Modern Healthcare. 2018.</p> <p>7. Atkinson J. An Analysis of the Medicare Hospital 5-Star Rating and a comparison with Quality Penalties. JKTG Foundation 11 Dec 2016 http://jktgfoundationorg/data/An_Analysis_of_the_Medicare_Hospital_5-Spdf.</p> <p>8. Cutlip DE, Fischman DL. Mortality After Percutaneous Coronary Intervention: Narrowing the Knowledge Gap. Circ Cardiovasc Interv. 2018;11(7):e007008.</p> <p>9. O'Brien SM, Cohen DJ, Rumsfeld JS, et al. Variation in Hospital Risk-Adjusted Mortality Rates Following Transcatheter Aortic Valve Replacement in the United States: A Report From the Society of Thoracic Surgeons/American College of Cardiology Transcatheter Valve Therapy Registry. Circ Cardiovasc Qual Outcomes. 2016;9(5):560-565.</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Finally, CMS solicits input on whether the agency should consider introducing a user-customized Star Rating tool on Hospital Compare. Generally, we are in favor of CMS developing a user-customization tool. To ensure the tool provides sufficient usability and utility, however, there would need to be an understanding that customized star ratings do not actually impact the CMS nationally reported star ratings.	Peter M. Leibold, Chief Advocacy Officer, Ascension	Danielle.White@ascension.org	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	5.5 User-Customized Star Rating: Not in favor	Dale N. Schumacher, MD, MPH, President, Rockburn Institute	dale.schumacher@rockburn.org	Healthcare Performance Improvement Organization	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	User-Customized Star Rating	VCU Health System supports any endeavor to aid patients in selecting healthcare facilities that meet their needs. However, many of the current measures are for a limited population (i.e., 65 and older) and for specific conditions (e.g., heart attack, heart failure). It is unclear if this user-customized tool would provide information that help consumers better determine where to seek their care, or serve to further mislead consumers in important healthcare decisions.	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	eryn.leja@vcuhealth.org	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	We do not necessarily oppose the intention behind user-customized ratings but nevertheless feel that allowing consumers to set explicit measure group weights may introduce needless confusion. One alternative could be incorporating some of the most common clinical conditions and corresponding sets of weights appropriate to those conditions (e.g. higher AMI mortality/readmission weights specific to AMI patients), and another could be to separate hospital ratings by clinical conditions entirely as proposed by the AHA. In any case, much further discussion and refinement is clearly warranted until successful implementation of such a feature becomes feasible.	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	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*
3/29/2019	User-Customized Star Rating	Under my proposed approach, it would be easy to build a web interface that takes consumer-chosen weights across the Measure Groups, and calculates the scores for a selected group of hospitals.	Dan Adelman, Professor, University of Chicago Booth School of Business	Dan.Adelman@chicagobooth.edu	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	<p>Doing what is right for the patient should be the first thought in every ones mind during this update. Providing this level of customization to the users is likely to overwhelm them and could easily lead to misunderstandings about the care a facility really provides. Thus, our users were unanimously against this idea and thought that any level of incorporation would lead to greater confusion.</p> <p>As it relates to usability, our PFAC stated that they use Hospital Compare to determine which hospitals in the area provide the service they look for, and use word of mouth about patient satisfaction. Multiple people suggested that their use of Hospital Compare was limited to figuring out which services a hospital has, and not to the scores they have in those measures. Additionally, if this did end up going forward, that the user should be able to enter values for each domain so that it weights the star rating according to their preference. For instance, if seven domains have overall scores d1, d2, ..., d7 and corresponding weights x1, x2, ..., x7 specified by the user where $\sum x_i = 1$, then the overall hospital score should be $\sum d_i x_i$. This is inherently more complicated than what is provided in the original request on page 41. This method of providing an overall score would be congruent with the comment about hospitals using a star rating for quality improvement on pages 41 - 42 of the original request.</p> <p>As for utility, our PFAC recognized that there may be benefit for some consumers and facilities to be able to customize a star rating, but that CMS should publish an Overall Hospital Quality Star Rating to keep everything consistent. Our hospital staff, however, thought that the hospitals don't use the Overall Hospital Quality Star Rating to drive improvement, yet they do use the components that feed the Overall Hospital Quality Star Rating for improvement activities. For this reason, our hospital staff suggested that CMS focus less on this particular aspect of consumer flexibility and customizability and more on designing meaningful measures and better data collection methods, especially with all of the recent changes in Core Measures.</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report

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3/29/2019	User-Customized Star Rating	As for validity of such a tool, our users had multiple concerns. The primary concern was allowing users to customize ratings means organizations could shape public perception about the facility by publishing their chosen version of a star rating on their front facing websites, which could be misleading to consumers. This concern is getting at the use of “alternative facts” in today’s society. Our PFAC doesn’t believe an organization should have the ability to shape the perception of their care, and that the care should speak for itself. All other concerns stemmed from this idea. One of our users suggested that individual states should have state wide star rating systems independent of the federal government. They also suggested that any update be modeled after the leapfrog website.	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	<ul style="list-style-type: none"> • Support the concept, but it is pre-mature. • Patient-oriented. • User determined measures and weights may or may not reflect the true quality of care provided. 	Deede Wang, MS, MBA, PMP, Manager of Data Analytics; Vanderbilt University Medical Center	deede.wang@vumc.org	Medical University	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	Vizient commends CMS for considering this innovative approach to place measure importance in the public’s hands. However, given the Hospital Star Rating current complexity, Vizient sees challenges in the public’s ability to understand the measures driving the ratings or finding measures that pertain to their particular needs or questions. Many of the measures used in the Star Ratings contain detailed, complicated algorithms that may be challenging for the average consumer to understand. Additionally, many of the main measures represented in the Star Ratings focus on limited clinical conditions such as heart failure, hip and knee replacements or COPD, which may not be the patient’s specific condition or need. A final step towards making the user-customized Star Ratings more informative to patients would be the inclusion of patient-reported outcome measures – which measure mobility, mental status and overall well-being. These measures compare providers based on questions that the average patient may find themselves wondering, such as ‘how soon will I return to work?’ or ‘when can I go running again?’ and answer the questions patients really want to know when they seek treatment. Unfortunately, our current health care measuring systems do not incorporate these measures and therefore miss an opportunity ripe for user-customization.	Shoshana Krilow, Vice President of Public Policy and Government Relations; Vizient, Inc.	Chelsea.arnone@vizientinc.com	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*
3/29/2019	User-Customized Star Rating	MGH appreciates and echoes the need for better reflection of individual patient values and preferences in ratings of quality and safety. MGH proposes to display and report the overall star rating with the pre-defined, accepted domain and measure weights, and then provide patients with the additional option to specify their own measures and weights in a separate portal. This would allow CMS to report one consistent overall star rating with measures and weights endorsed by quality experts, yet also provides flexibility for patients to customize their view accordingly.	Elizabeth Mort, MD, MPH, Senior Vice President of Quality & Safety, Chief Quality Officer, Massachusetts General Hospital	emort@partners.org	Medical University	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	In the Public Input Request, CMS indicates that it is considering a user-customized Star Rating tool to take into consideration the values and preferences of patients and consumers. CMS states that user-customization would allow for patient preferences and calculate a star rating personalized for the user's values. While we appreciate the interest in making the ratings more user-customized and taking into consideration the preferences of the patient, we are very concerned that such a tool may be overly complex, burdensome and create more confusion for the consumer. Balanced scorecards are used in consumer reports type references and easy for consumers to understand. We urge CMS to show the performance on each domain that contributes to the overall star rating as the best way to provide consumers the ability to focus on the performance areas that matter most to them. We strongly urge CMS to NOT pursue consumer-customized star ratings. If CMS moves forward on such an option, we urge CMS to engage a variety of stakeholders to fully understand consumer needs and the components needed for a valuable tool.	George Blike, Chief Quality & Value Officer; Dartmouth-Hitchcock Health	George.t.blike@hit.chcock.org	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*
3/29/2019	User-Customized Star Rating	<p>AHPA does not support the introduction of user-customization to the Overall Hospital Star Rating. Given the variability in patient population and preferences, it would be increasingly difficult for hospitals to develop targeted policies around any set of quality measures and achieve a higher star rating. If the explicit approach attempts to address provider concerns over predictability and interpretability of the weights, user-customization reverses it.</p> <p>Furthermore, using a user-customized star rating tool might create a perverse incentive. If over time hospitals find a pattern in how their patients are using the customized ranking, they might focus on those measures more. For example, if Timeliness and Patient Experience are more heavily weighted by most of the hospital's population, those measures may pull focus away from other clinically important measures such as Mortality or Safety. To encourage customization, an alternative approach would be to provide separate ratings for each of the measure groups in addition to maintaining the Overall Hospital Star Rating. This would allow CMS to address different priorities, preferences or values among patients. AHPA also believes that CMS should consider using an alternative approach to encourage the development of different hospital rating platforms by providing raw data to the private sector. Giving technology companies access to hospital quality rating data and offering incentives could lead to the development of software applications that meets the needs of the public.</p>	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	My opinion is that CMS is over thinking this one. I would recommend a framework similar to NYS DOH's consumer guides for health plans (https://www.health.ny.gov/health_care/managed_care/consumer_guides/) where each domain has its own star rating (as determined against all hospitals). Then consumers could compare domains of interest across hospitals of interest, maybe being able to filter hospitals based on hospital characteristics like specialties, bed size, etc.	Laura Morris, MS, CPHQ, Senior Business Analyst for Quality	lmorris@glensfalls Hosp.org	Individual	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	We think the tool is confusing as it is and there is not a need to introduce more complexity at this time. If the current issues are addressed and more consensus is built among the provider communities, additional options could be included at that time.	Jean Cherry, FACHE, Executive Vice President, Med Center Health	jean.cherry@mchealth.net	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*
3/29/2019	User-Customized Star Rating	CMS should continually test novel approaches for ensuring the information available on the Compare websites is meaningful to consumers. For example, CMS could consider creating patient-centric dashboards where users weight areas of care that are most important to them and then receive quality reports with related information. Premier does not believe the hospital star rating program has reached the necessary level of maturity to allow user-customized ratings. Before considering this option, CMS should address concerns with program validity, stability and interpretability. We are concerned that in the absence of a transparent methodology, hospitals will be unable to discuss with patients why the star rating varies between patients.	Blair Childs, Senior vice president for public affairs; Premier Healthcare Alliance	aisha_pittman@premierinc.com	Healthcare improvement company	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	<p>CMS’s suggestion of user-customized ratings hints at an approach that would better serve the needs of consumers. However, the exact proposal (allowing consumers to rate the importance of each domain) is likely to cause confusion and misinformation. We cannot expect consumers to be well-versed in abstract, intuitively overlapping quality concepts like “safety of care”, “patient experience”, and “effectiveness of care,” let alone express well-formed preferences over those concepts.</p> <p>Why do consumers look for a hospital? They do not engage in the pursuit as an academic exercise, seeking to find the “best” overall hospital. Consumers search for a hospital in the context of some particular need, that is, some condition or procedure. This search is typically is constrained by location (the ability or means to travel only a certain distance), insurance coverage, and cost. We do not believe the current star ratings help consumers pick a high-quality hospital given this search paradigm. Ignoring this comes at the peril of ignoring what consumers actually need in an already confusing healthcare landscape.</p> <p>In order to achieve the goals set out by the program, we believe user-customization should flow from why and how patients actually search for and utilize healthcare, by asking consumers for the specific procedures or conditions important to them. From there, the ratings should be based on specific performance thresholds that define quality based on the literature and best practices for those conditions or procedures.</p>	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	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	User-Customized Star Rating	For a particular procedure or a condition, these ratings should use the same measures across hospitals. The system could also allow consumers to view the ratings of hospitals within some distance from their home zip code, and perhaps filter by which hospitals accept their insurance. We appreciate these are non-trivial changes that go well beyond the proposed enhancements, but believe they are necessary to achieve the stated goals of the program and help patients.	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	Please refer to the Summary Report
3/29/2019	User-Customized Star Rating	As CMS is considering user customization of the ratings, an option for users to view score improvements at the organization level will ease interpretation of scores and enhance user understanding of improving or worsening performance over time. Given the complexity of dual scoring approaches of both absolute performance and for improved performance, however, incorporation into the Overall Hospital Quality Star Rating is unlikely to make interpretation easier for patients and consumers.	Kirstin Hahn-Cover, MD, FACP, Chief Quality Officer; University of Missouri Health Care	hahncoverk@health.missouri.edu	Medical University	Please refer to the Summary Report

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3/29/2019	User-Customized Star Rating	<p>We generally support CMS creating more dynamic functionality of the Overall Hospital Quality Star Rating tool, allowing patients and consumers to compare hospitals according to their own preferences and values. However, allowing individuals to alter hospitals' Overall Hospital Quality Star Ratings based on individual preferences could further undermine the utility of the Overall Hospital Quality Star Rating as a valid quality measure and performance benchmark. An alternative option that we encourage CMS to consider is to display overall star ratings for each of the underlying group measures, e.g., Timely and Effective Care, Unplanned Hospital Visits, etc. We note that, in addition to the Overall Hospital Quality Star Rating, CMS displays a HCAHPS Star Rating as an indicator of overall patient experience of care at a particular hospital, but no other group measure includes an overall star rating. We believe that including star ratings at the more granular group measure level would be meaningful both to individuals and to hospitals and provide a greater incentive for hospital improvement. It would allow patients and consumers to more easily compare hospitals at the level of the group measures about which they are most interested or place the highest value. For hospitals, it could allow for more targeted improvement efforts and potentially result in increased quality for many hospitals. For example, if two competing hospitals both score average on their Overall Hospital Quality Star Rating, they may have relatively little incentive to improve based on that metric alone. However, if these two hospitals score differently on overall Complications and Deaths and overall Unplanned Hospital Visits, each hospital would have a greater incentive to improve the area in which they score lower.</p>	Kaycee M. Glavich, Director of Policy, Press Ganey	kaycee.glavich@pressganey.com	Individual	Please refer to the Summary Report

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2/28/2019	Beyond the Scope of Star Ratings Project	<p>2. Readmission scores are adjusted for hospital volume. This adversely impacts the scores for some large hospitals.</p> <p>The use of Hierarchical Logistic Regression Models for mortality, readmissions, and complications and PSI-90 reliability adjustment adversely impacts rankings of large vs small hospitals.</p> <p>It has been previously shown that volume adjustment leads to lower thresholds for reporting poor performance for larger hospitals(1,2)</p> <p>Volume adjustment is employed by HRRP as a strategy to minimize the effect of variability seen in low volume centers. This approach, also called “shrinkage” is a well-accepted approach to reduce the chance that identified outliers are not simply the result of variability due to low volumes of cases. There is a difference, however, in adjusting for volume to detect true poor performers – the objective of the HRRP – and ranking based on the results of scoring – which is the goal of the stars program.</p> <p>[Figures 8a-8b] show varying linear relationship between CMS corrected readmission rates and raw readmission rates depending on hospital size.</p> <p>References:</p> <p>1.Sosunov EA, Egorova NN, Lin H-M, McCardle K, Sharma V, Gelijns AC, et al. The Impact of Hospital Size on CMS Hospital Profiling. Med Care. 2016 Apr 1;54(4):373–9.</p> <p>2.Joynt KE, Jha AK. Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program. JAMA. 2013 Jan 23;309(4):342.</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>	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report

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2/28/2019	Beyond the Scope of Star Ratings Project	<p>[Figures 9a-9e]</p> <p>In an attempt to adjust results for statistical variability in small volumes, corrections done by the Hierarchical Logistic Regression Models have unintended and confusing consequences. By adjusting for low volume in the measures, low volume hospitals, as a group, are adjusted toward the mean, displacing high volume hospitals to the high and low extremes. What is counter intuitive is that low volumes are typically associated with poorer outcomes in the medical literature. As shown below, when comparing low and high volume centers, the lower volume center with a worse raw 30-day readmission rate is ultimately rated higher than a high volume center with a better raw 30-day readmissions rate.</p> <p>[Table 3]</p> <p>Data obtained from Hospital Compare files at data.medicare.gov</p> <p>Despite a 43.2% raw readmission rate, the small hospital in Texas is ranked ahead of large hospitals in Chicago and Detroit for Heart Failure.</p> <p>[Figure 10]</p> <p>[Table 4]</p> <p>Data obtained from Hospital Compare files at data.medicare.gov</p> <p>Excluding volume correction, small hospital in Texas' readmission rate improves while integrity of ranking is maintained. Large hospitals in Chicago and Detroit retain a higher ranking.</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>Thomas_A_Webb@rush.edu</p>	Medical University	Please refer to the Summary Report

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2/28/2019	Beyond the Scope of Star Ratings Project	<p>While unable to test HWR directly due to suppression of actual readmissions, the same model principals are employed in HWR, as with Heart Failure. In the Dec 2017 Release, the small hospital in Texas was corrected more than the large hospital in Detroit based on CMS' adjusted measures, despite the larger hospital having better raw 30-day readmission rates. This results in the large hospital in Detroit receiving a worse Readmission Domain score, as shown in [Table 5].</p> <p>Data obtained from Hospital Compare files at data.medicare.gov</p> <p>* Small Hospital in Texas ranks in the Bottom 1% for HF, Bottom 1% for AMI, and Bottom 35% of PN based on raw readmissions</p> <p>On a larger scale, the Hierarchical Logistic Regression Model's impact on ranking can be seen in the following two charts. Smaller hospitals are compressed to the middle and larger hospitals are displaced to the extremes.</p> <p>[Figures 8a-8b]</p> <p>Data obtained from Hospital Compare files at data.medicare.gov</p> <p>Volume adjustment of outcome scores propagate through the entire star system as these models influence three domains and 66% of the total score.</p> <p>[Table 6] shows no small hospitals (based on HWR volume) have a 1-star and 8% have a 2-star, where 37% of large hospitals have 1 or 2 stars.</p> <p>[Table 6]</p> <p>This difference isn't due to many more large hospitals providing poor quality but a measurement system that when used for ranking creates winners and losers based on size alone.</p> <ul style="list-style-type: none"> • The Overall Rating is heavily based on Hierarchical Logistic Regression Models. These models create bias in results based on hospital size. 	<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>	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report
3/2/2019	Beyond the Scope of Star Ratings Project	<p>One of my health care providers is not honoring my e-mail concerns that I have posted on their web page. How do I get them to answer my concerns?</p>	John Janosky Jr	johnjanoskyjr@gmail.com	Individual	Please refer to the Summary Report
3/6/2019	Beyond the Scope of Star Ratings Project	<p>I am an 80 year old white male. I have been in many EMERGENCY ROOMS, e.g. Dartmouth-Hitchcock Hospital, Queens Hospital, Cornell-Weil, etc. All were satisfactory EXCEPT Wilcox Hospital, in Lihue, Kauai, Hawaii. This should be restaffed or closed. Nary a doctor, hostile nurses, wrong diagnoses.</p>	Jon Appleton	appletonaloha@gmail.com	Individual	Please refer to the Summary Report

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3/11/2019	Beyond the Scope of Star Ratings Project	Eliminate HCAHPS from the survey. A safety net county hospital can never attain the same satisfaction scores as a boutique hospital that delivers babies and only accepts only paid customers. Two totally different organizations. This is just one example. But Just because a hospital is noisy at night (one of the HCAHPS questions) does not reflect the quality of care provided or patient outcomes.	Monica Hamilton, MHA, BSN, RN, CPQH, Natividad	hamiltonm@natividad.com	Hospital	Please refer to the Summary Report
3/18/2019	Beyond Scope of Star Ratings Project	Regarding the measures themselves, there are two new metrics we would recommend you add. Based on the fact that patient compliance with referrals is significantly enhanced (increased by 60-100%, depending on the population: 60% for commercially-insured patients and 100% for state-insured patient populations) when their referral appointment is booked or confirmed while they are at the point of care, i.e. the emergency department or hospital inpatient setting, and the observation that common current practice is to discharge patients with only a suggested care plan that becomes the patient's responsibility – the result is the lower-than-healthy compliance rates of today, which are reflected in poorer health outcomes and increased readmission and complication rates. To address this obvious gap in care by making it explicitly the caregivers' responsibility to engage in ensuring the patient's follow-through to referrals, we offer these two additional measures: To the "Patient Experience" category, add: Patients who reported that their referral visit to a specialist was scheduled or confirmed prior to leaving the emergency department or hospital. To the "Effectiveness of Care" category, add: Percentage of patients who are referred to a specialist or primary care provider for appropriate follow-up visit after an emergency department visit that did not lead to hospitalization.	Vytas Kisielius, Chief Executive Officer, ReferWell	vytas@referwell.com	Healthcare Performance Improvement Co.	Please refer to the Summary Report
3/18/2019	Beyond Scope of Star Ratings Project	As a statistician/mathematician working in healthcare, initially when I read specs on various measures, it was difficult to find logic defined. Eventually I find the most important information was in the Appendix with convoluted text descriptions. I would like to suggest to use pseudo-code to describe the logic, constraints and algorithms. This, hopefully, will eliminate any potential misunderstanding.	Xu Ashton, Quality Office, UT Southwestern Medical Center	xu.ashton@UTSouthwestern.edu	Medical University	Please refer to the Summary Report

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3/18/2019	Beyond Scope of Star Ratings Project	Removing 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.	Autumnjoy Leonard, Clinical Quality Compliance Auditor, Summit Healthcare Regional Medical Center	aleonard@summithealthcare.net	Hospital	Please refer to the Summary Report
3/19/2019	Beyond Scope of Star Ratings Project	<p>Additionally, any notion that patient experience (as determined by standardized Press Ganey questions) is an actual measure of hospital quality is absurd. This is supported by studies in the ER setting demonstrating that positive press ganey scores are associated with higher patient mortality rates. We all know that press ganey scores have directly contributed to the opioid epidemic as well; and this needs to be stopped.</p> <p>Regarding readmissions, newer studies suggest that 7 day readmission rates are a better measure for hospital performance than 30 day readmission rates. While we strive to work collaboratively with community partners to reduce readmission rates, unilateral accountability (in the form of financial punishment and STAR rating punishment) for this performance is problematic. CMS should strongly consider transitioning to 7 day readmissions as a measure of inpatient performance rather than the 30 day measure. Using the 30 day measure simply forces hospitals to fund community programs for which there is no mechanism to recover costs.</p>	Seger S. Morris, D.O., MBA, Hospitalist & Associate Clinical Professor of Internal Medicine, Magnolia Regional Health Center	SMorris@mrhc.org	Individual	Please refer to the Summary Report
3/27/2019	Beyond Scope of Star Ratings Project	<p>UC Health's Star Ratings Methodology Concerns</p> <p>Measures form the cornerstone of the Hospital Compare Star Ratings methodology. Efforts to adjust the Star Rating methodology, so that a hospital's component score better reflects the quality of care delivered at the given hospital, must address head on deficiencies in the methodology's underlying measures and how they are weighted. UC Health has consistently requested that more of the Star Rating measures be revised and reweighted (i.e., the PSI-90 measure) to account for appropriate social-risk adjustment of the sociodemographic factors typical of patients treated by academic medical centers, like UC Health, that serve as both safety net provider and teaching hospital. For example, CMS's Star Ratings methodology should require adjustment of measures for patients who are low-income, non-native English speakers, and or without regular sources of outpatient care.</p>	John Stobo, MD, Executive Vice President, University of California Health System	Julie.Clements@ucdc.edu	Health System	Please refer to the Summary Report

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3/27/2019	Beyond Scope of Star Ratings Project	UC Health's Star Ratings Methodology Recommendations Reform specific measures, like the PSI 90, which undergird the Star Ratings methodology and by being weighted so heavily have the effect of distorting CMS's representation of the high quality of care typically provided by highly respected safety net academic medical centers.	John Stobo, MD, Executive Vice President, University of California Health System	Julie.Clements@ucdc.edu	Health System	Please refer to the Summary Report
3/27/2019	Beyond Scope of Star Ratings Project	In addition I would add that patients should certainly have a voice indicating what they feel is important to care which could be accomplished in focus groups where the measures can be better explained and understood. Many of the measures within effectiveness, imaging and timeliness are misleading due to their categorization and we should not risk misunderstanding as a vote of confidence on the patient/consumer preference. Equally the exploration of patient values should not be relegated to only those measures which are currently used. Price transparency, access, and continuity of care could be more important factors to patients in our current healthcare landscape.	Daniel J. Baker, MD, MBA, Medical Director ,Lenox Hill Hospital	djbaker@northwell.edu	Individual	Please refer to the Summary Report
3/28/2019	Beyond Scope of Star Ratings Project	Going forward, CMS should ensure that measures included in the calculation of star rating are valid and reliable. Specifically, we recommend that CMS remove the PSI 90 composite measure entirely from the star ratings and only include NQF-endorsed measures.	Michael Young, MHA, President & Chief Executive Officer, Temple University Hospital; Henry Pitt, MD, Chief Quality Officer, Temple University Health System	henry.pitt@tuhs.temple.edu	Health System	Please refer to the Summary Report
3/28/2019	Beyond Scope of Star Ratings Project	The Patient Safety Indicators (PSIS) are also incongruent with MHACS/PPCs and creates a double penalty in the “present upon admission” situation. A huge current drawback is the 30-day mortality rates not showcasing the true ICD-10 code of expiration. A death could be caused by an unavoidable event unrelated to the hospital, but the hospital will be penalized for the mortality.	Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center	kdonaghy@wmhs.com	Health System	Please refer to the Summary Report

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3/28/2019	Beyond Scope of Star Ratings Project	As mentioned above, an algorithm which uses “observed to expected values” should be part of the new rating system. However, the “expected values” metric should be risk-adjusted based on population factors (e.g., age, sex, comorbidity, diagnosis, socioeconomic status, etc.). Hospitals are still struggling with implementing the submission of electronic clinical quality measures (e.g., coding is not clear, there are issues with personnel competency, and some states do not currently validate submitted data), which results in a star rating that is very misleading and questionable.	Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center	kdonaghy@wmhs.com	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Ratings Project	That said, we continue to have concerns with the PSIs as valid measures of hospital quality. The PSIs were originally developed to serve as a flag to hospitals of potential safety events, not to serve as definitive performance measures. We would recommend that CMS not use PSIs for star ratings, and continue working to identify better measures for capturing rates of these patient safety events.	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Ratings Project	Patient Socioeconomic Status (SES): The lack of adjustment of the readmission measures for patient social risk factors continues to be a serious concern, especially for hospitals that serve disproportionately vulnerable populations. The Johns Hopkins Hospital treats large numbers of patients who face many challenges upon discharge, including housing insecurity, food insecurity, and poor transportation options. We recommend that CMS remove the readmission measures from the Overall Quality Hospital Star Rating until they are adjusted for such risk factors. Some of the concern with the readmission measures and the lack of adjustment for patient SES could be mitigated by the introduction of peer grouping.	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report
3/29/2019	Beyond the Scope of Star Ratings Project	Readmission rate is one of the lowest in the country, due to our extensive networking with post-acute providers and discharge planning. So our expense problems are not caused by readmission. Thirdly, the one area where Erlanger has lower costs than normal is additional proof of these inequities in the measurement system. Hip and Knee replacements are procedures where the acuity of the patients is more equally balanced in this region, and we can avoid expenses like helicopters and inpatient rehab services. Please take this comment into consideration when making any adjustments for the Hospital Quality Star Rating methodology.	Janessa Dockery, Administrative Fellow, Erlanger Health System	Janessa.Dockery@erlanger.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond the Scope of Star Ratings Project	Adjusting readmission scoring based on hospital size penalizes larger hospitals while smaller hospital are pushed to the mean whether their performance is good or bad. Incorporating a confidence interval in the adjustment of readmissions based on hospital size would improve the negative impact on larger hospitals.	Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	ZSFG urges CMS to transition PSI measures out of all measurement programs. 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, rates derived from the measures are highly flawed and should not be used to assess hospital quality.	Troy Williams, RN, MSN, Chief Quality Officer; Zuckerberg San Francisco General Hospital and Trauma Center	leslie.safier@sfdph.org	Hospital	Please refer to the Summary Report
3/29/2019	Beyond the Scope of Star Ratings Project	The second comment is towards the Medicare Spending per Beneficiary methodology. Erlanger has been consistently rated as 'above normal' spend, but the in-hospital spend rates are usually below average. Where Erlanger is penalized is for spend three days prior to admission, and the post-admission expenses. The primary reason for penalties three days prior to admission is that Erlanger is a regional center with a much higher proportion of patients that are flown in by helicopter, and by longer distance ground ambulance, compared to most hospitals. Since CMS pays for these services separately, this causes the prior-to-admission cost to be significantly higher than average. Secondly, the post-discharge expenses are also 'higher than average' for Erlanger because the population served tends to have more significant co- morbidities, and these patients tend to have a higher rate of need for post-acute inpatient rehab services. Inpatient rehab is the most expensive post-discharge service that is available other than readmission to the hospital. In addition, our Hospital Wide	Janessa Dockery, Administrative Fellow, Erlanger Health System	Janessa.Dockery@erlanger.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Ratings Project	<p>HANYS previously provided the following comments to CMS to inform its research of alternative approaches to improve the readmission measures and to make appropriate changes to the Readmissions Reduction Program and other value-based payment programs:</p> <ul style="list-style-type: none"> •Consider the inclusion of other sociodemographic status risk factors. The Centers for Disease Control and Prevention defines social determinants of health as “the set of factors that contribute to the social patterning of health, disease, and illness.”¹ Dual eligibility is only one out of the 17 social risk indicators studied by the National Academy of Medicine that are associated with health outcomes and healthcare utilization.² Though restraints exist in terms of data available for some of these risk factors, others, including dual eligibility for Medicare and Medicaid, have data available or at least “some data available for use.”³ CMS should develop risk-adjustment models that incorporate dual eligibility and other social factors to more comprehensively capture their social impacts on health. •Risk-adjust at individual measure level. CMS’ traditional risk-adjustment models are developed for individual readmission measures. They differ from each other by including different disease diagnoses, comorbidities, prior use of medical services, etc.ⁱⁱⁱ The same approach holds promise for SDS adjustment. SDS factors, by influencing different aspects of risk behaviors and disease progress patterns, might increase readmission risks at varying levels for different underlying medical conditions. <p>¹ Centers for Disease Control and Prevention. NCHHSTP Social Determinants of Health. Accessed June 7, 2017, at https://www.cdc.gov/nchhstp/socialdeterminants/faq.html</p> <p>¹ Buntin, M.B. and Ayanian, J.Z. Social risk factors and equity in Medicare payment. N Engl J Med. 2017; 376 (6): 507-510.</p> <p>¹ Centers for Medicare and Medicaid Services. 2013 measures updates and specifications report: hospital- level 30-day risk-standardized readmission measures for acute myocardial infarction, heart failure and pneumonia. Access June 7, 2017, at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html</p>	Marie Grause, RN, JD, President, Healthcare Association of New York State	lwillis@hanys.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Ratings Project	Instead, we urge CMS to continue its efforts under the Meaningful Measures program to identify those that are most reflective of true quality outcomes and account for important local SDS and economic influences. Such measures need to be straightforward, easy to find and easy to understand so every consumer can get precise information to inform personal healthcare choices.	Marie Grause, RN, JD, President, Healthcare Association of New York State	lwillis@hanys.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond the Scope of Star Ratings Project	Thank you for the opportunity to comment on the Overall Hospital Quality Star Rating on Hospital Compare. This comment focuses on two specific topics to address future considerations for the methodology. The first comment is towards the Mortality Risk Adjustment Methodology. Erlanger's culture has always been to serve patients with complex diseases and diagnosis in combination with the most co-morbid conditions. For example, Erlanger is nationally known for its Stroke program, and hospitals regularly tour Erlanger to understand opportunities for improvement. But, Erlanger has a "Worse than National" rating for Stroke mortality. The problem is that it is difficult to accurately reflect the risk of mortality based on UB-04 charges, also known as the CMS-2450 form, in combination with the fact that any Stroke that has any risk will come to Erlanger. This same concept applies to all Diagnosis-specific mortality ratings.	Janessa Dockery, Administrative Fellow, Erlanger Health System	Janessa.Dockery@erlanger.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond the Scope of Star Ratings Project	Richmond University Medical Center joins with many of its health care colleagues in strongly opposing the structure of the current star rating system, especially in the areas of readmissions and the Hospital-Acquired Conditions (HAC) Penalty Program. The readmissions program is not a true measure of hospital quality because the current adopted 30-day readmission measure for six clinical conditions is a timeframe that goes far beyond what the hospital itself can control. Rather than being a reflection of hospital quality, it is more a measure of patient and caregiver compliance with post-discharge instructions, availability of transportation, and access to appropriate community-based follow-up care. Our hospital, similar to all safety net hospitals, faces unique challenges to address the socioeconomic needs of our patient population. These include housing and food insecurity, poor health literacy, not having a regular source of primary or specialty care, or no family member to help with post-discharge care. We are working hard through our involvement in New York State's Delivery System Reform Incentive Payment (DSRIP) program and the Staten Island Performing Provider System (SI PPS) to address these patient needs. All of the above mentioned community demographics correlate to worse patient outcomes. It is the mission of RUMC to serve our diverse community and we should not be unfairly penalized because of our patient population.	Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center	ALutz@RUMCSL.org	Medical University	Please refer to the Summary Report
3/29/2019	Beyond the Scope of Star Ratings Project	In relation to the current Hospital-Acquired Conditions (HAC) Penalty Program, we disagree with the structure of the program. The current HAC penalty program indiscriminately penalizes one-quarter of the nation's hospitals, without regard to whether the hospital is performing well on the measures or hospital specific improvements in complication rates. Since hospitals are simply ranked, the statistical significance of performance differences is not considered. Also the current methodology essentially assigns rural and small community hospitals the national average performance, rarely do they receive a penalty because they have little opportunity to be in the bottom quartile. This results in large, urban teaching hospitals, like RUMC, being disproportionately penalized	Alex Lutz, Director of Public Relations & Marketing, Richmond University Medical Center	ALutz@RUMCSL.org	Medical University	Please refer to the Summary Report

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3/29/2019	Beyond the Scope of Star Ratings Project	<p>Improve Underlying Measures: CMS should improve existing measures in use in the hospital quality reporting and performance programs, including the incorporation of sociodemographic factors in measure-level risk adjustment. CMS should remove PSI-90 from the Star Ratings. Some of the components of the measure focus on surgical care, which disadvantages teaching institutions that tend to have a larger volume of surgical cases than do other hospitals. Further, the PSI-90 tends to penalize hospitals that have large volumes of surgeries, even where the probability of an adverse event is the same as a low-volume hospital. Additionally, some components of the measure are susceptible to surveillance bias and therefore institutions that are more diligent about reporting safety events are penalized^{1,2}. For example, teaching institutions tend to have robust infection control programs, which focus on identifying and reporting patient safety events. Finally, the measure is based on administrative claims data so cannot capture the full scope of patient-level risk factors.^{1,2,3}</p> <p>While the modified composite may be an improvement over the previous version, many of the issues previously cited in comments to the Agency continue to apply, and because of this, CMS should remove the PSI-90 measure from the Star Ratings methodology. LVHN urges CMS to improve upon existing</p> <p>¹ Koenig, Lane et al. Complication Rates, Hospital Size, and Bias in the CMS Hospital-Acquired Condition Reduction Program. American Journal of Medical Quality. December 19, 2016. Retrieved from: https://journals.sagepub.com/doi/abs/10.1177/1062860616681840</p> <p>² Blay Jr., Eddie et al. Evaluating the Impact of Venous Thromboembolism Outcome Measure on the PSI 90 Composite Quality Metric. The Joint Commission Journal on Quality and Patient Safety. March 2019. Retrieve from: https://www.jointcommissionjournal.com/article/S1553-7250(18)30220-4/pdf</p> <p>³ “MedPAC Comments on FY 2014 IPPS Proposed Rule.” June 25, 2013. Retrieved from: http://www.medpac.gov/documents/comment-letters/medpac's-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0</p>	Matthew McCambridge, M.D. MS, FACP, FCCP SVP and Chief Quality and Patient Safety Officer, Lehigh Valley Health Network	Chris.Deschler@lvhn.org	Health system	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>We know that socio-demographic factors often vary between types of insurance. We further know that different types of insurance have different levels of benefits and of cost sharing requirements on patients that could impact their utilization of health care services, including appropriate following of medical treatment recommendations, such as the taking of prescription medications.</p> <p>Therefore, it would also be useful to examine if there is capability and validity in showing measures for each hospital by payer category, such as Medicare, Medicaid, Dual Eligible, Uninsured, Employer and Individual Market. Ideally this comparison would have information specific for people with high deductible plans. Any such comparison, however, would also need to account for differences in clinical risks of the respective population as some hospitals see healthier or more health challenged populations.</p> <p>If it became possible to provide accurate quality data by payor source that accounted for both social and clinical risk factors then patients with different sources of coverage would have even better information on options that they should consider. A further benefit would be the ability see how changes in types of coverage are impacting patient quality and outcomes.</p> <p>The Patient Safety and Adverse Event measure has many flaws for multiple reasons. In part the flaws relate to it being a composite measure based on both claims and administrative data where the administrative data cannot fully account for the impact of patient-level risk factors. Its flaws disadvantage teaching hospitals that have a larger volume of surgical cases and more complicated surgery cases than a lower volume hospital or who have more robust infection control and other quality tracking programs that identify and report safety events.</p>	Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center	Jennifer.carlson@osumc.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Remove the PSI-90 composite score. The PSI-90 composite measure is based on administrative claims and it has numerous concerns given some of the measure constructs focus on surgical care, which disadvantages teaching institutions that tend to have a larger volume of surgical cases than do other hospitals. The PSI-90 tends to penalize large surgical volume hospitals even where the probability of an adverse event is the same as a low-volume hospital. Some components of the measure are susceptible to surveillance bias as teaching institutions that have robust infection control programs or focus on identifying and reporting patient safety events, are penalized.</p> <p>Patients with frequent readmissions, disproportionately affect the readmission score and hospital star rating. The readmission domain in CMS' Overall Rating accounts for 22% of the total score. There are 9 measures evaluated by the Latent Variable Model (LVM) yet only one is chosen (the hospital-wide all-cause unplanned readmission measures-HWR) to represent the domain. The loading coefficient from the LVM for HWR is perfectly correlated. Regions Hospital, like Rush University Medical Center (RUMC), is a tertiary care program, accepts complex, critically ill patients who are often referred for a higher level of care. Regions and like hospitals, accept and treat these high acuity outliers which are not excluded from HWR this can have a negative impact on performance relative to centers with lower acuity.</p> <p>Readmission scores are adjusted for hospital volume, adversely impacting the scores for some large hospitals. The use of the Hierarchical Logistical Regression Models for readmissions, mortality, and complications as well as the PSI-90 reliability adjustment adversely impacts ranking of large versus small hospitals. It is appropriate to adjust for volume to meet the objective of the HRRP but not for ranking based on the results of scoring which is the objective of the Stars program. The Overall Rating is heavily based on the Hierarchical Logistic Regression Models, creating bias in results based on hospital size.</p>	Bret Haake, MD, Vice President of Medical Affairs, Chief Medical Officer; Regions Hospital	seamus.b.dolan@healthpartners.com	Hospital	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Urges CMS to continue to revisit its current use of the PSI measure. We ask that the agency remove this measure from every public reporting program due to the measure's challenges.</p> <p>CHA appreciates the opportunity to provide comments on the proposed changes and looks forward to continued engagement with CMS. If you have any questions, please do not hesitate to contact me at</p>	Alyssa Keefe, Vice President of Federal Regulatory Affairs, California Hospital Association	nhoffman@calhospital.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	There is a significant body of evidence that indicates that PSIs are insensitive and inaccurate, and correlate poorly with harder quality outcomes. For example, in one study the sensitivities of the PSIs compared with NSQIP validated safety events ranged from 19–56% for original PSI definitions and 37–63% using alternative PSI definitions, while positive predictive values (PPVs) were only 22–74% ¹ . Using insensitive and inaccurate measures on a small non-representative sample of inpatient stays seems a poor indicator of overall quality of care, therefore we do not support including the individual PSI measure scores for the safety domain	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>Actively following measure groupings for consistency in how much each measure influences the measure group score over time</p> <p>Because the weighting of each metric fluctuates between each star rating report under the current methodology, a hospital could make significant improvement in a majority of its patient safety/readmission/mortality/experience metrics and still receive fewer stars in the next CMS release². The latent variable model hampers improvement efforts given that this blinds the hospital system which, ideally, looks to provide the highest level of patient care. We explore alternatives in the “Overall Hospital Quality Star Rating Methodology” section of our comments.</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>The stated goal of the Hospital Compare methodology is to provide consumers with a simple overall rating to help guide their decision on where to receive care⁴. Implicit in this directive is that the target audience - the “typical” American consumer – benefits because of the simplicity of the rating system. Given that very highly-educated academics and clinicians continue to debate over the complex methodology employed by CMS in calculating these ratings^{2,7}, we believe the consumer will continue to benefit from a simple, composite score approach rather than transferring greater responsibility onto the consumer requiring them to</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>understand additional mathematical complexities. In fact, for more advanced consumers who desire in- depth analysis, Hospital Compare already displays performance by measure group (mortality, patient experience, etc.) to further distinguish hospitals in the area(s) which may be of greater particular interest to a specific consumer. To illustrate how a customizable approach might lead to confusion, imagine a consumer using a customizable tool to select a hospital for an elective percutaneous coronary intervention (PCI) – a procedure with a mortality of well below 1%⁸. Given this procedure is relatively safe, an anxious consumer might over-weight mortality (comparing a hospital with mortality of 0.2% versus 0.4%) in a customizable tool despite the minimal absolute risk difference. In this case, the differential PCI quality care between hospitals is more likely to be evidenced by differences in patient experience and safety. On the other hand, a consumer needing to select a hospital for a higher-risk aortic valve replacement (AVR) procedure might unknowingly underestimate the importance of mortality – in this case they might fail to adequately distinguish the difference between a hospital with a 5% versus 10% mortality risk⁹, which should be at the forefront of a consumer’s mind for such high-risk procedures. Because academics and clinicians continue to debate and refine the weighting of different quality metrics, it is unfair and potentially unsafe to push this responsibility onto the consumer without a much more thorough assessment of the risks and benefits.</p> <p>2. Castellucci M. CMS hospital star-rating system has been wrong for two years, health system finds. Modern Healthcare. 2018.</p> <p>7. Atkinson J. An Analysis of the Medicare Hospital 5-Star Rating and a comparison with Quality Penalties. JKTG Foundation 11 Dec 2016 http://jktgfoundationorg/data/An_Analysis_of_the_Medicare_Hospital_5-Spdf.</p> <p>8. Cutlip DE, Fischman DL. Mortality After Percutaneous Coronary Intervention: Narrowing the Knowledge Gap. Circ Cardiovasc Interv. 2018;11(7):e007008.</p> <p>9. O'Brien SM, Cohen DJ, Rumsfeld JS, et al. Variation in Hospital Risk-Adjusted Mortality Rates Following Transcatheter Aortic Valve Replacement in the United States: A Report From the Society of Thoracic Surgeons/American College of Cardiology Transcatheter Valve Therapy Registry. Circ Cardiovasc Qual Outcomes. 2016;9(5):560-565.</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>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.</p> <p>We strongly urge CMS to reexamine its methodology and ensure the types of measures included will provide meaningful results of the greatest use to patients, account for the varying factors that affect hospitals' performance outcomes, and not disproportionately disadvantage essential hospitals.</p> <p>a. CMS should consider removal of the Patient Safety and Adverse Events (PSI 90) composite measure from the star ratings methodology.</p> <p>MIHS is concerned that the PSI 90 composite measure is an unreliable indicator of quality of care. The events in this claims-based measure occur infrequently; are susceptible to surveillance bias; lack appropriate and necessary exclusions; might not be preventable through evidence-based practices; and are based on administrative claims data that cannot capture the full scope of patient-level risk factors.^{1,2} Further, the PSI 90 composite measure focuses on surgical issues and, therefore, disproportionately influences ratings for academic medical centers safety net hospitals, which see a larger volume of complex surgical cases. Placing excessive emphasis on claims-based data unreliably represents a hospital's actual progress in improving quality. We urge CMS to recalculate the star ratings with the removal of the PSI-90 composite measure.</p> <p>1 Rajaram R, et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. JAMA. 2015;313(9):897–898.</p> <p>2 Cassidy A. Medicare's Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015.</p> <p>http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142. Accessed June 4, 2018.</p>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Further input from stakeholders is needed to evaluate, both conceptually and empirically, the impact of regrouping and new group weights. Patients might seek care for services and treatments that simply are not reflected in the available measure data. In addition, the star ratings might make inappropriate assumptions about what matters most to patients facing particular health care decisions. We urge CMS first to consider the types of measures that will provide meaningful results (that are most useful to patients) and take into account the different factors that affect hospitals' performance outcomes.</p> <p>Additionally, measures will be removed from Hospital Compare as CMS implements its Meaningful Measures initiative, with the goal of identifying high-priority areas for quality measurement and improvement and reducing provider burden. We urge the agency to only include measures in the star ratings that are endorsed by the National Quality Forum (NQF). CMS should ensure the star ratings measure set, in its current state and as amended by any future addition or removal of measures, includes only NQF-endorsed measures that are valid, reliable, and aligned with other existing measures.</p>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>a. CMS should risk adjust measures in the methodology to account for the socioeconomic and sociodemographic factors that complicate care for vulnerable patients.</p> <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.¹ 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</p>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>example—and socioeconomic status, such as income and education, can influence health outcomes.⁴ 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, we serve a disproportionate share of lower-income patients with compounding sociodemographic factors and might receive a lower rating for reasons outside its control.</p> <p>While MIHS 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 safety net 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. Maricopa Integrated Health System urges CMS to include factors related to a patient’s background—including sociodemographic status, language, and post discharge support structure—in the risk-adjustment methodology for star ratings.</p> <p>3. See, e.g., National Quality Forum Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed March 14, 2019.</p> <p>4. America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed March 14, 2019.</p>	Stephen A. Purves, FACHE, President & CEO, Maricopa Integrated Health System	Warren.Whitney@mihs.org	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	Specific to the PSI-90, it is our concern, and our understanding that CMS shares this concern, that the PSI-90 may not accurately reflect quality, and that specific measures within the PSI-90 may be weighted too heavily. It is also concerning that the scoring of the PSI-90 has varied significantly since 2017 and could contribute to significant changes in overall Star Ratings. A more specific measure or measures should be considered that more accurately reflect hospital quality.	Karen Braman, Senior Vice President, Healthcare Strategy and Policy Kansas Hospital Association	kbraman@khanet.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Hospitals that care for poor communities may be at an unfair disadvantage based on the current Star Ratings methodology.</p> <p>A specific comment on the format of how information is displayed for small hospitals - for small hospitals, such as critical access hospitals that have too few patients to report on a particular safety measure, rather than CMS stating “no data to report”, it is recommended that CMS provide a clear statement such as “not enough data to report” to clarify that the measure is not applicable to that hospital rather than potentially giving consumers the incorrect perception that the hospital did not report their data or made an oversight.</p> <p>Finally, KHA agrees with AHA’s recommendations to CMS to engage experts on the latent variable model to ensure accurate calculation, and examine how to best mitigate the impact of outliers in calculating readmissions measures in the ratings. Providing meaningful, accurate quality data in an easy to understand format is such a complex issue with significant implications for consumers and providers that we ask CMS to suspend the Star Ratings until problems with the methodology are addressed in a comprehensive way. We believe that more than thirty days is needed to seek and analyze feedback on the methodology and ask that CMS continue to seek public input as it works to enhance the validity of Star Ratings.</p>	Karen Braman, Senior Vice President, Healthcare Strategy and Policy Kansas Hospital Association	kbraman@khanet.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>Other proposed changes. As noted earlier, this letter’s attachment includes MHA’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.</p> <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, MHA continues to urge CMS to transition PSI measures out of all of its measurement programs. MHA has long been concerned by the significant limitations of PSIs as a quality measure. PSIs use hospital claims data to identify patients that 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</p>	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	measures are poorly suited to drawing meaningful conclusions about hospital performance on safety issues. The measures were intended by their developers to screen for potential quality events rather than to confirm them. PSIs flag complications of care but not preventable or avoidable events that would signal deficient care. 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” – that is, 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 validity and reliability when applied to Medicare claims data.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	Readmissions measure outliers. MHA urges CMS to explore strategies to mitigate the impact of outliers in calculating the readmission measures used in star ratings. 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. Focus more on improvement than penalties. MHA urges CMS to consider more programs to educate or guide hospitals to improve quality, in addition to penalty programs. All hospitals strive to provide the best patient care possible; CMS should lead the way by providing more resources to guide improvement, rather than focusing on punitive programs. The star ratings essentially punish (or reward) hospitals twice for the same measures found in other CMS payment programs, such as those for Hospital Acquired Conditions and Readmissions. Hospitals that struggle in these areas end up being punished in multiple arenas, and losing payments takes away critical dollars that could otherwise go towards improving quality, particularly for safety net hospitals.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	Encourage measures consistent with IMPACT 2014. Create groupings that encourage Service Line aggregations.	Dale N. Schumacher, MD, MPH, President, Rockburn Institute	dale.schumacher@rockburn.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Incorporate Sociodemographic Status (SDS) Factors into Measure-Level Risk Adjustment</p> <p>Approximately two-thirds of hospital's Star Rating is based on its readmissions, morality, and patient experience performance. There is significant peer-reviewed literature' demonstrating that hospital performance on these outcomes can be affected by factors outside the control of the hospital (e.g., housing, food insecurity, social support, and transportation). Furthermore, Congress recognized that hospitals that disproportionately care for vulnerable patient populations, who are at a higher risk of readmissions, are disadvantaged when these factors are not considered in the payment scoring methodology and mandated that CMS adjust hospital readmission penalties for the proportion of dually eligible patients under the Hospital Readmission Reduction Program. CMS has implemented this adjustment through stratifying penalties by the proportion of Medicare and Medicaid dual- eligible patients the hospital serves. This stratification is only the first step toward accurate risk adjustment for patients with social and economic challenges. CMS must go beyond adjusting only payments to also adjusting the underlying measures in order to make accurate quality comparisons.</p> <p>One promising avenue for incorporating SDS factors into measure-level risk adjustment is the National Quality Forum (NQF)'s NQP Social Determinants of Health Data Integration Project which ensures that measure developers are improving measures currently in use by incorporating critical SOS data elements into measure risk adjustment when possible. UCMC urges CMS to work with NQF on this effort.</p> <p>Remove PSI-90 from Star Ratings</p> <p>UCMC has concerns with the PSI-90 composite measure. Some of the components of the measure focus on surgical care, which disadvantages teaching institutions that tend to have a larger volume of surgical cases than do other hospitals. Further, the PSJ-90 tends to penalize hospitals that have large volumes of surgeries, even where the probability of an adverse event is the same as a low volume hospital.</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; 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>	benjamin.gibson@uchospitals.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Additionally, some components of the measure are susceptible to surveillance bias and therefore institutions that are more diligent about reporting safety events are penalized. 3 For example, teaching institutions tend to have robust safety and infection control programs, which focus on identifying and reporting patient safety and infection events. Finally, the measure is based on administrative claims data so cannot capture the full scope of patient-level risk factors."·6 While the modified composite may be an improvement over the previous version, many of the issues previously cited in comments to the Agency continue to apply, and because of this, CMS should remove the PSI-90 measure from the Star Ratings methodology.</p> <p>3 See National Academies of Sciences, Engineering, and Medicine. 2016-2017. Report Series: Accounting for Social Risk Factors In Medicare, PQ)mu,t, Washington, DC: The National Academies Press. Details here: https://www.nationalacademies.org/perspectives/2017/03/29/Accounting-for-Social-Risk-Factors-In-Medicare-PQmu,t-Washington-DC-The-National-Academies-Press-Details-here</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; Stephen Weber, MD, Professor of Medicine, Chief Medical Officer, VP Clinical Effectiveness, VP Governmental Affairs, University of Chicago Medicine; Ben Gibson, VP for Governmental Affairs</p>	benjamin.gibson@uchospitals.edu	Medical University	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>Include appropriate and equal volume adjustments so to not disadvantage large volume hospitals. For example, readmission scores inadvertently penalize hospitals with large volumes.</p> <p>Remove PSI-90 measure. It is a claims-based measure with low volume, that doesn't allow for patient level risk factors and adjustments.</p> <p>Include improved risk-adjustment and inclusion of socio-economic status for readmissions to be consistent with the Readmission Reduction Penalty program.</p>	<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</p>	dmilling@buffalo.edu	Medical University	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>CMS should work to further stratify hospitals to better risk adjust and reflect the measurement of clinical outcomes, and in particular, the resource utilizations required to achieve true population health. The current measurement structure unnecessarily rewards hospitals with wealthier patient populations that have the resources to better manage health outside of the health care system. It also has the potential to impact a patient's confidence in their care simply by virtue of how the data is displayed. Safety net hospitals can be equally or more efficient with resource utilization but reflect as a poor performer simply because the patient populations served require higher use of resources to maintain health status outside the health care system. Moreover, in populations where health care decisions are often impacted by the ability to pay, these measures for comparison and payment can lead patients to inappropriate conclusions about where their care will be best managed.</p> <p>As a national model for the delivery of urban healthcare, SUHI has defined the use of Community Health Workers to drive outcomes and connect patients to available resources in an urban setting. Wealthier, and often suburban, health care systems do not face this challenge as the patients are often well equipped to furnish these resources on their own, and have long historical trends of education, availability of simple resources such as food, housing and transportation, and significantly higher access to care across the continuum outside of a health system. Prejudicing the safety net systems through measurement in this manner only exacerbates the disparity in care and negates the benefits of a true population health approach with extensive community outreach.</p>	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinai.org	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>We strongly urge CMS to reexamine its methodology and ensure the types of measures included will provide meaningful results of the greatest use to patients, account for the varying factors that affect hospitals' performance outcomes, and not disproportionately disadvantage essential hospitals.</p> <p><u>a.</u> CMS should consider removal of the Patient Safety and Adverse Events (PSI 90) composite measure from the star ratings methodology.</p> <p>America's Essential Hospitals is concerned that the PSI 90 composite measure is an unreliable indicator of quality of care. The events in this claims-based measure occur infrequently; are susceptible to surveillance bias; lack appropriate and</p>	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>necessary exclusions; might not be preventable through evidence-based practices; and are based on administrative claims data that cannot capture the full scope of patient-level risk factors.^{1,2} Further, the PSI 90 composite measure focuses on surgical issues and, therefore, disproportionately influences ratings for academic medical centers and essential hospitals, which see a larger volume of complex surgical cases. Placing excessive emphasis on claims-based data unreliably represents a hospital's actual progress in improving quality. We urge CMS to recalculate the star ratings with the removal of the PSI-90 composite measure. Further input from stakeholders is needed to evaluate, both conceptually and empirically, the impact of regrouping and new group weights. Patients might seek care for services and treatments that simply are not reflected in the available measure data. In addition, the star ratings might make inappropriate assumptions about what matters most to patients facing particular health care decisions. We urge CMS first to consider the types of measures that will provide meaningful results (that are most useful to patients) and take into account the different factors that affect hospitals' performance outcomes.</p> <p>Additionally, measures will be removed from Hospital Compare as CMS implements its Meaningful Measures initiative, with the goal of identifying high-priority areas for quality measurement and improvement and reducing provider burden. We urge the agency to only include measures in the star ratings that are endorsed by the National Quality Forum (NQF). CMS should ensure the star ratings measure set, in its current state and as amended by any future addition or removal of measures, includes only NQF-endorsed measures that are valid, reliable, and aligned with other existing measures.</p> <p>2. Rajaram R, et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. JAMA. 2015;313(9):897–898.</p> <p>3. Cassidy A. Medicare's Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142. Accessed June 4, 2018.</p>	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>We strongly urge CMS to reexamine its methodology and ensure the types of measures included will provide meaningful results of the greatest use to patients, account for the varying factors that affect hospitals' performance outcomes, and not disproportionately disadvantage essential hospitals.</p> <p>a. CMS should consider removal of the Patient Safety and Adverse Events (PSI 90) composite measure from the star ratings methodology.</p> <p>America's Essential Hospitals is concerned that the PSI 90 composite measure is an unreliable indicator of quality of care. The events in this claims-based measure occur infrequently; are susceptible to surveillance bias; lack appropriate and necessary exclusions; might not be preventable through evidence-based practices; and are based on administrative claims data that cannot capture the full scope of patient-level risk factors.^{1,2} Further, the PSI 90 composite measure focuses on surgical issues and, therefore, disproportionately influences ratings for academic medical centers and essential hospitals, which see a larger volume of complex surgical cases. Placing excessive emphasis on claims-based data unreliably represents a hospital's actual progress in improving quality. We urge CMS to recalculate the star ratings with the removal of the PSI-90 composite measure. Further input from stakeholders is needed to evaluate, both conceptually and empirically, the impact of regrouping and new group weights. Patients might seek care for services and treatments that simply are not reflected in the available measure data. In addition, the star ratings might make inappropriate assumptions about what matters most to patients facing particular health care decisions. We urge CMS first to consider the types of measures that will provide meaningful results (that are most useful to patients) and take into account the different factors that affect hospitals' performance outcomes.</p> <p>Additionally, measures will be removed from Hospital Compare as CMS implements its Meaningful Measures initiative, with the goal of identifying high-priority areas for quality measurement and improvement and reducing provider burden. We urge the agency to only include measures in the star ratings that are endorsed by the National Quality Forum (NQF). CMS should ensure the star ratings measure set, in its current state and as amended by any future addition or removal of measures, includes only NQF-endorsed measures that are valid, reliable, and aligned with other existing measures.</p>	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinaui.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>In addition to this, while patient experience measures are of vital importance to both measure quality of care and to help patients made an informed choice, the current methodology does not appropriately risk adjust or weight measures that are largely impacted by the needs of patients related to cultural competence, limited English proficiency and social determinants of health. In addition to this, the manner in which surveys are administered is further prejudicial to those delivering high caliber care to populations with high levels of homelessness, poverty, and complex socioeconomic situations. As an organization, we recommend the creation of evidence based questions that measure the processes designed to address these needs, and which will better equip these patients to make an informed choice and further drive the quality of care forward. We also recommend the exploration of different mechanisms to survey so that the feedback of these complex populations can be better incorporated into the measures.</p> <p>2. Rajaram R, et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. JAMA. 2015;313(9):897–898.</p> <p>3. Cassidy A. Medicare’s Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142. Accessed June 4, 2018.</p>	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinai.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<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>	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<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>	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinai.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	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.	Bruce Siegel, MD, MPH, President and CEO, America's Essential Hospitals	mguinan@essentialhospitals.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	CMS should take strategic steps to ensure confidence, by all stakeholders, in the star ratings program and the information it is intended to provide. CMS should first work to build a comprehensive data platform that reflects current and risk adjusted actual data instead of publishing years-old claims based data which is often driven by the documentation requirements created by CMS itself. These measures further reflect a coding system that hasn't been in use since 2015, and attempt to combine coded data that isn't even congruent with each other to arrive at a global assessment of quality. We recommend not only an annual refresh, but the development of an evidence based measurement system designed to assess true complications in a more real time way, and the measures being taken to prevent them, with appropriate risk adjustment and consideration of the populations served and their access to care, medications, and treatment, the infrastructure of which is largely defined by CMS itself. 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.	Mira Iliescu-Levin, SHS VP/CMO of Acute Hospitals, Sinai Health System	maria.iliescu@sinaui.org	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	In addition to peer grouping, appropriate measure by measure socioeconomic risk adjustments are needed, to allow for closer like to like comparison. Star ratings fail to account for social risk factor differences across hospitals. Two-thirds of a hospital's star rating is based on its readmissions, mortality and patient experience performance. There is significant peer-reviewed literature - well summarized by the National Academy of Medicine's series of reports in 2016 and 2017 - showing that hospital performance on these outcomes 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. 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.	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 & Safety First Programs; VCU Health System	eryn.leja@vcuhealth.org	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<ul style="list-style-type: none"> We likewise agree with Rush that socioeconomic status should be integrated into the risk-adjustment process for readmissions measures, especially since this is already the case within CMS' Hospital Readmissions Reduction Program (HRRP). We furthermore feel that mortality measures and THA/TKA complications should also account for socioeconomic status. 	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<ul style="list-style-type: none"> Alongside the Association of American Medical Colleges (AAMC) and American Hospital Association (AHA), we urge that PSI-90 be removed from the Safety of Care measure group due to serious concerns over the accuracy of administrative billing data that its component PSIs are derived from. For example, one study from Ohio State University examined all PSIs flagged at a six-hospital academic medical center in 2014: they reversed 6.7% of PSIs due to inherent AHRQ algorithm limitations and 28.2% of PSIs overall. Likewise, we also propose that PSI-04 be removed from the Mortality measure group because patients are included in this measure even if their adverse outcome was present-on-admission but the corresponding diagnosis code was not listed in the primary position. We have some major concerns with the THA/TKA complications measure. First, its risk- adjustment model has poor discrimination (C=0.65), unfairly penalizing hospitals operating on patients with significantly higher disease burden. Second, for at least two years of the 2014-2017 data collection period, second-stage prosthesis reinsertions for infected knee joints (which carry considerably higher infection rates) were inappropriately captured by this measure by way of incorrect DRG assignation. Therefore, we propose that this measure be removed from the Star Ratings until these concerns are abated. <p>Finally, in the spirit of comprehensiveness, UPMC greatly encourages YNHHS/CORE to seriously consider incorporating into the Star Ratings a robust set of reliable quality measures beyond merely those reported on Hospital Compare. As just one example, both the Leapfrog Hospital Safety Grade and the US News and World Report Best Hospitals ratings systems encompass process/structural measures from the American Hospital Association (AHA) Annual Survey of Hospitals. Undertaking this step alone would accomplish much to ensure that the Star Ratings becomes a truly trustworthy resource for healthcare quality assessment and decision making.</p>	Tami Minnier, RN, MSN, FACHE, Chief Quality Officer, University Pittsburgh Medical Center	Panzarellolm@upmc.edu	Hospital	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	<p>Incorporate Sociodemographic Status (SDS) Factors into Measure-Level Risk Adjustment</p> <p>Upon consideration of the current flaws with the Hospital Quality Star Rating Model, we recommend the following changes:</p> <p>1.Incorporate a measure-level risk adjustment for Socioeconomic Status (SES) Factors. Many of our hospitals provide disproportionate care for patient populations which have significant economic and demographic disadvantage, and it is well demonstrated in the medical literature that this impacts patient outcomes in areas beyond the control of the hospital. Further, the factors that are heavily weighted in the Star Rating Model (such as readmissions, patient experience, and mortality) are particularly vulnerable to the influence of these socioeconomic factors. This effectively penalizes hospitals which disproportionately care for our nation's more vulnerable populations.</p>	Stephen R.T. Evans, MD, Executive Vice President and Chief Medical Officer, MedStar Health; Rollins J. (Terry) Fairbanks, MD, VP, Quality and Safety, MedStar Health	Tony.Calabria@Medstar.net	Health System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	<p>Random Comments</p> <p>Our conversations produced two random comments that should be shared with this evaluation:</p> <p>We would like to be able to clearly look at Hospital Compare and compare (i) which measures they submitted and (ii) how they performed on those measures. This is currently possible, but it is time consuming and laborious. Note that this is different than being able to pick facilities and compare their Overall Hospital Quality Star Rating.</p> <p>We would like CMS to consider adding a question on discharge follow-up phone calls to the patient satisfaction domains explicitly. This is shown to reduce readmissions and “close the loop” on patient care post-discharge.</p>	Joshua Fetbrandt, Quality Analyst, Tahoe Forest Health System	joshua.fetbrandt@gmail.com	Health System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	Specific to the PSI-90, it is our concern, and our understanding that the Kansas Hospital Association and the American Hospital Association shares this concern, that the PSI-90 may not accurately reflect quality, and that specific measures within the PSI-90 are weighted too heavily. The PSI-90 has a disproportionate influence on the safety score. In general, Olathe Medical Center does not agree that a claims based measure such as PSI-90 provides an accurate measure of quality for consumers. Claims data do not fully reflect the details of a patient's history, course of care and clinical risk factors. PSI data can assist hospitals in identifying patients whose particular cases need additional review and further investigation with the full medical record, but we do not believe the PSI 90, particularly as currently weighted, helps consumers draw accurate conclusions about a hospital's safety performance. Olathe Medical Center encourages CMS to consider either eliminating the PSI 90 or reevaluating the current weighting methodology.	Cathy Wiens, MHA, Vice President/Quality and Compliance; Olathe Medical Center	cathy.wiens@olath.ehealth.org	Hospital	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	CAHs function as vital sources for hospital care in remote, rural communities. As a result, CAHs typically have very low patient volume. The Star Rating Program's evaluation of CAH quality necessarily relies on measures that are heavily influenced by sample size. For CAHs, a single infection, readmission, or mortality event carries a significant impact to hospital performance, even though the circumstances may be out of the CAHs control. Large acute care hospitals, with high patient volume, have the ability to balance out aberrant results that CAHs simply do not.	Rob Bloom, CFO; Carthage Area Hospital	rbloom@cahny.org	Hospital	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	For the Safety of Care group, we also recommend removing the PSI-90 composite measure. Research has found many deficiencies with PSI-90, which include the following: susceptible to surveillance bias; may not be preventable through evidence-based practices; lacks appropriate and necessary exclusions; and are based on administrative claims data so cannot capture the full scope of patient-level risk factors. ¹ The current PSI-90 measure is also hospital-specific and does not capture harm throughout the entire continuum of care. We believe that CMS should invest in methodologies that capture harm in a more accurate and comprehensive manner. This should involve capturing data that reflects the patient experience across the full health care continuum, including the hospital, ambulatory and post-acute care settings.	Carlyle Walton, FACHE, President; Adventist Health Policy Association	Carlyle.walton@adventhealth.com	Healthcare System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating Project	Related, we further note that our paper referenced above (Fontana et al. 2019, https://journals.lww.com/jbjsa/Abstract/latest/When_Stars_Do_Not_Align__Over_all_Hospital_Quality.99927.aspx , also see attached) indicates that there are perhaps significant consequences to not including complications after hip and knee replacement among low-volume hospitals (i.e., those that perform fewer than 25 but greater than zero such surgeries). The fact that imputing low-volume quality measures for 3 other surgical quality measures did not impact the star rating also calls into question the face validity of the methodology. It is unclear how our analyses would be impacted by these alternative precision strategies, but we urge CMS to take seriously the implications of the volume-outcome relationship; valid rating schemes should be consistent with that well-researched relationship.	Mark Alan Fontana, PhD, Senior Director of Data Science, Center for Advancement of Value in Musculoskeletal Care, Hospital for Special Surgery	fontanam@hss.edu	Medical University	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating Project	Examine how to mitigate the impact of outliers in calculating readmissions measures in the ratings.	Dr. Ferdinand Velasco, Senior Vice President, Chief Health Information Officer, Texas Health Resources	joelballew@texashalth.org	Healthcare System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating project	We urge CMS to recalculate the star ratings with the removal of the PSI-90 composite measure. Strategies to reduce the impact of readmission outliers should be explored. Until the effect of the Hospital Readmissions Reduction Program (HRRP) is better understood, CMS should remove the measure from the star ratings. Several recent peer-reviewed publications question the benefit of the HRRP. One study suggested that the HRRP had less of a reduction in readmission rates than initially stated. Several other studies have indicated that the HRRP may be associated with an increase in mortality in certain populations. This potential for a misalignment between what is best for our patients and what is best for our star ratings is obviously not desirable.	Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare	Daniel.hoody@hennepinmed.org	Healthcare System	Please refer to the Summary Report

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3/29/2019	Beyond Scope of Star Rating project	CMS should test additional methods of risk adjustment for social risk factors. Methods that have been successful include using geocoding at the block group or census tract level and then using area-level variables from sources such as census data as an indicator of social risk for individuals. Purchased consumer data has also been successfully used as an indicator of social risk for purposes of risk adjusting provider performance measures. The National Quality Forum recommends that when there is a conceptual basis for a relationship between social risk and a provider performance measure, and empirical evidence of such a relationship exists, social risk factors should be included in the risk adjustment model.	Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare	Daniel.hoody@hcm.org	Healthcare System	Please refer to the Summary Report
3/29/2019	Beyond Scope of Star Rating project	Potential Future Methodology Updates GNYHA has an in-house team of economists, statisticians, and analysts who routinely support regulators and legislators in the development of payment, performance measurement, and performance-based payment policies for the Medicare and Medicaid programs. Ideally, policymakers make the data and methodology available to allow our team and other stakeholders to replicate the results, validate the methods—and in the event systematic bias or technical issues are identified—develop specific recommendations to address the concerns. While the Centers for Medicare & Medicaid Services (CMS) has described potential refinements to the star ratings methodology, we are unable to provide specific comments on many of the proposals at this time because insufficient information is available to assess their impact. Therefore, GNYHA requests that as part of CMS’s continuing evaluation of the star ratings, it develop specific proposals for consideration by stakeholders and provide another opportunity for public comment. In addition, as part of the review period, the Yale School of Medicine Center for Outcomes Research & Evaluation (CORE) should release its research database and a revised SAS pack so that stakeholders can replicate the analysis. Until such time, we request CMS suspend public release of the star ratings.	Elisabeth R. Wynn, Executive Vice President, Health Economics & Finance, Greater New York Hospital Association	achin@gnyha.org	Hospital Association	Please refer to the Summary Report

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2/28/2019	Additional Comments on the Overall Star Ratings	<p>1. Patients with frequent readmissions, though rare, disproportionately affect the readmission score and hospital star rating.</p> <p>The Readmission Domain in CMS' Overall Rating accounts for 22% of the total score. Despite nine measures evaluated by the Latent Variable Model, only one was chosen by the model to calculate this portion of the Overall Rating. The one measure is the Hospital-Wide All-Cause Unplanned Readmission measure. [Table 7], from CMS' Hospital Specific Report, confirms that the Loading Coefficient, determined by the Latent Variable Model, for HWR has perfect correlation (Loading Coefficient = 1.0) to the Readmission Domain score and further supported by [Figure 11].</p> <p>[Table 7]</p> <p>[Figure 11]</p> <p>Data from 20 Hospital Specific Reports confirm the perfectly linear relationship identified from the loading coefficients between the Readmission Domain score and the HWR measure.</p> <p>Rush University Medical Center (RUMC), a tertiary care program, accepts complex, critically ill patients. Many times, the patients are referred to our hospital for a higher level of care. Accepting and treating these acuity outliers put RUMC, and hospitals like RUMC, at a risk for lower performance in the HWR measure and the Overall Rating.</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>	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report

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2/28/2019	Additional Comments on the Overall Star Ratings	<p>[Figure 12]</p> <p>This histogram [Figure 12] shows the distribution of patients by number of readmissions during the period of July 2016 through June 2017. Four (4) patients accounted for 36 total 30-day readmissions.</p> <p>Without these four patients, RUMC's raw (un-adjusted) HWR would drop from 17.3% to 16.9%, enough to change RUMC from a 4-star to a 5-star hospital in the Feb 2019 release, if the Dec 2017 cutoffs are consistent.</p> <p>Patient Profiles</p> <p>Patient 1: Decompensated Liver Transplant did not make to transplant. Managed complications of recurrent bleeding that could only be treated with transplant. Clinically reviewed readmissions as unavoidable.</p> <p>Patient 2: Routinely misses dialysis and comes to ED when confused. Readmitted for HD and management of renal encephalopathy that resolves after HD. Clinically reviewed readmissions as unavoidable.</p> <p>Patient 3: Patient with suprapubic catheter, recurrent UTIs, ulcers non-healing. Clinically reviewed readmissions as unavoidable.</p> <p>Patient 4: Patient with end stage renal disease and NO access obtainable at outside hospitals, transferred and managed with a Hero catheter requiring multiple hospitalizations to maintain graft. Clinically reviewed readmissions as unavoidable.</p> <ul style="list-style-type: none"> • The Readmission Domain is linked to the Hospital Wide Readmission (HWR) measure exclusively. For tertiary care centers, the treatment of high acuity outliers, which are not excluded from HWR, can negatively impact performance relative to centers with lower acuity 	<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>Thomas_A_Webb@rush.edu</p>	Medical University	Please refer to the Summary Report
2/28/2019	Additional Comments on the Overall Star Ratings	<p>As a facility, we are continuously reviewing practices to improve both patient care and performance. We have found that, upon reviewing our star ratings report, there are areas in which we need improvement for our care and performance to be the best it possible can for the community we serve.</p> <p>We would like to see a guide or road map published that will assist facilities in how to improve the services they provide as it is measures per the Star Ratings report.</p> <p>Thank you for your time and consideration in this most important issue.</p>	<p>Wendy H. Shurette, MSN, RN, CPHQ, Quality Nurse, Coosa Valley Medical Center</p>	<p>Wendy.Shurette@cvhealth.net</p>	Hospital	Please refer to the Summary Report

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3/11/2019	Additional Comments on the Overall Star Ratings	The measures chosen for the overall star rating should also be reconsidered as to how they related to overall quality of care provided by a hospital, per the healthcare consumer.	Rhonda Unruh, MHA, RN, CIC, Vice President of Quality, Guadalupe Regional Medical Center	runruh@grmedcenter.com	Individual	Please refer to the Summary Report
3/15/2019	Additional Comments on the Overall Star Ratings	-new HQR platform. I would like to be able to see all of my hospitals with one log in. -Maybe all of the HC data could only be updated twice a year? -Sepsis measure is still very controversial. Should not be publicly reported or algorithm should be worked on to make data points in sepsis bundle more straight forward.	Kathy J. Nunemacher MSN, RN, CPN, CPHQ St. Luke's University Health Network Network Director; Clinical Quality Data Governance and Reporting	Kathy.Nunemacher@sluhn.org	Individual	Please refer to the Summary Report
3/25/2019	Additional Comments on the Overall Star Ratings	Another concern we have with the current methodology is its artificial adjustment of our results based on volume. While our organization is adequately sized to accommodate the care needs of our rural region, our size causes the denominator used in some of our quality metric calculations to be low. The current Star Rating methodology artificially adjusts our results for those measures in an attempt to avoid volatility in the data over time due to the small denominators used in the calculations. However, this type of adjustment negatively impacts us. For example, even if Benefis reports zero CLABSI in a given period, our CLABSI score is adjusted downward based on a "prediction" that we potentially may have had CLABSIs to report if we had seen more patients during the period. We disagree with this methodology and believe that publicly reported outcomes should be based on actual rather than predicted data. Further, we recommend that measures for which a given hospital does not garner sufficient volume to report a statistically valid outcome be excluded completely from that hospital's publicly reported results.	Greg Tierney, MD, Chief Medical Officer and Medical Group President, Benefis Health System	juliewall@benefis.org	Health System	Please refer to the Summary Report

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3/28/2019	Additional Comments on the Overall Star Ratings	In 2015 and 2016 Ortho Nebraska Hospital had 5-star ratings. In 2017 and 2018 our ratings changed to N/A. Starting in 2017, Ortho Nebraska did not meet the minimum data requirement of three measure groups (one of which must be an Outcome measure group). In 2015-2016 our Safety of Care (Outcome measure), HAI 6 (C-diff) had a numerator of zero reported, but for 2017 and 2018 the numerator was listed as N/A. We inquired to CMS for an explanation of the numerator change. Their response included: “For HAI 6 (C-diff), CDC NHSN measures, the predicted number of infections must be at least one for the SIR (Standardized Infection Ratio) to be calculated. The predicted infections for HAI 6 (C-diff) is less than one for Ortho Nebraska so results display as N/A and were not used when calculating the Star Rating”. So in essence, OrthoNebraska Hospital is being penalized by exceeding the care expected and receiving a N/A in the Hospital Compare Overall Quality Star Rating.	Christine Ellet, RN, MSN, CPHRM, Quality Manager, Ortho Nebraska Hospital	Christine.Ellett@OrthoNebraska.com	Hospital	Please refer to the Summary Report
3/28/2019	Additional Comments on the Overall Star Ratings	By implementing a new methodology, the public should be able to understand the rating system at a fourth-grade level. The results should show expanded metrics for several services or metrics that would be of interest to the public. Negative findings should not be showcased; only the metrics scored in a positive range should be displayed. This rating system would then provide the public the best hospital for a particular service versus a hospital that may not have that service listed due to either not providing the service or not delivering the service in the appropriate range.	Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center	kdonaghy@wmhs.com	Health System	Please refer to the Summary Report
3/28/2019	Additional Comments on the Overall Star Ratings	CMS should look at the website impressions to see if the public is accessing the site to view star ratings. The current site is not user-friendly and is difficult to maneuver. The public should also be shown what data is being measured, and the data should be explained in layman’s terms so lower-grade reading levels can comprehend the information. Another option would be to show only specific measures and aggregate the data into star ratings based on specific patient populations of care.	Kate Donaghy, Director, Community Relations and Marketing, Western Maryland Regional Medical Center	kdonaghy@wmhs.com	Health System	Please refer to the Summary Report

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3/28/2019	Additional Comments on the Overall Star Ratings	Weighting: We remain concerned with the current weights that are assigned to the measure group score domains. While we understand that the current weights were vetted through multiple stakeholder groups, we fail to understand why equal weights are assigned to Readmissions (22%) and Mortality (22%). It seems unlikely that a majority of patients, physicians or others would consider these two outcomes to be equal. CMS should repeat their vetting of the weights by providing stakeholder groups with a “clean slate” for identifying their values and preference.	Allen Kachalia, MD, JD, Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine	kachalia@jhu.edu	Health Organization	Please refer to the Summary Report
3/28/2019	Additional Comments on the Overall Star Ratings	<p>We also wonder if providing a few additional options to allow development of the statistical toolkit might be helpful:</p> <p>1) Providing a test data set with known characteristics to allow developers to recreate the statistical models in other software packages (e.g. Python and/or R) and know if the performance of these methods improves efficiency. We have seen anecdotal evidence that implementations of the SAS code in python are more performant.</p> <p>2) Providing scripts that cross walk from the VRDC to appropriate inputs to the SAS code, which will allow those with access to the VRDC to be able to recreate and iterate the public SAS code</p> <p>3) Provide a pathway for proposed revisions to established methods from technical experts and the open source community, via “crowd sourced” implementations using #1 and #2 above. These suggestions may accelerate advances from an enthusiastic community. This could also lay the foundation for valid community implementations of quality measurement that leverage the blue button API.</p>	<p>Dr. 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 Chicago, Illinois; Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious; Diseases/Department of Medicine Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center</p>	Thomas_A_Webb@rush.edu	Medical University	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*
3/28/2019	Additional Comments on the Overall Star Ratings	Additional RUMC Comments: Incorporating measure precision at the individual measure level based on hospital denominator has created unintended consequences of un-evenly distributing star ratings by hospital size. Size adjustment in the Hierarchical Logistic Regression Models for Mortality and Readmissions cause small hospitals to be clustered in the middle of rankings where large hospitals are pushed to the ranking extremes. This cannot continue.	Dr. 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 Chicago, Illinois; Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine; Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center	Thomas_A_Webb@rush.edu	Medical University	Please refer to the Summary Report

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3/28/2019	Additional Comments on the Overall Star Ratings	We would also recommend the exploration of the impact of outliers on the readmission score. For example, if a hospital has complex patients with a higher risk of repeat readmissions, this can currently lead to excess HRRP penalties for the hospital. We believe that a cap of the number of readmissions a single patient can contribute to the overall score should be introduced. This way single patients cannot exert undue influence on the readmission risk per hospital, especially in these measures with narrow distributions.	Dr. 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 Chicago, Illinois; Dr. Bala Hota, Vice President, Chief Analytics Officer, Associate CMO Associate CIO; Rush University Medical Center Professor, Section of Infectious Diseases/Department of Medicine; Thomas A. Webb, MBA Manager, Quality Improvement; Rush University Medical Center	Thomas_A_Webb@rush.edu	Medical University	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*
3/28/2019	Additional Comments on the Overall Star Ratings	<p>While we support public reporting of provider quality data, we urge CMS ensure that this data adequately accounts for hospital patient mixes that include higher proportions of patients with multiple complex chronic health conditions and lower socioeconomic status.</p> <p>We want to make sure that the star rating system is not misleading to consumers because of flaws in the measures that underpin the ratings. For example, Spectrum Health hospitals, which are in the top echelon of other quality rating reports e.g. Healthgrades, and handle the most complex procedures and patients, will receive two, three or four stars (out of a possible five), creating confusion for providers who are trying to focus on improvement and patients who are trying to best engage in health care decision making.</p>	<p>Leslie M. Jurecko MD, MBA SVP, Quality, Safety, and Experience Spectrum Health Pediatric Hospitalist Assistant Professor of Pediatrics at Michigan State University, College of Human Medicine</p>	Leslie.Jurecko@spectrumhealth.org	Hospital	Please refer to the Summary Report
3/28/2019	Additional Comments on the Overall Star Ratings	<p>The following items are the AAMC's key recommendations on methodologic improvements:</p> <ul style="list-style-type: none"> •Suspend the Star Ratings: CMS should remove the publication of the Star Ratings from the Hospital Compare website until CMS is able to address significant concerns with the methodology. •Improve Underlying Measures: CMS should improve existing measures in use in the hospital quality reporting and performance programs, including the incorporation of sociodemographic factors in measure-level risk adjustment. CMS should remove PSI-90 from the Star Ratings. •Overall Composite Ratings Add to Confusion About Hospital Confusion: 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. The AAMC urges CMS to explore the template matching, or other approaches that directly compare patient groups, as a possible alternative model to use for rating h Improve the Underlying Quality Measures <p>An overall quality rating based upon individual quality measures can only ever be successful if the underlying measures themselves are reliable, valid, and incorporate appropriate and robust risk adjustment to accurately account for the differences in clinical and social risk of patients that a hospital serves.</p>	<p>Janis M. Orłowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges</p>	galee@aamc.org	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*
3/28/2019	Additional Comments on the Overall Star Ratings	<p>The AAMC urges CMS to improve upon existing measures in its hospital quality reporting and performance programs while also undertaking efforts to update and improve the Star Rating methodology.</p> <p>Incorporate Sociodemographic Status (SDS) Factors into Measure-Level Risk Adjustment Approximately two-thirds of a hospital's Star Rating is based on its readmissions, mortality, and patient experience performance. There is significant peer-reviewed literature¹ demonstrating that hospital performance on these outcomes can be affected by factors outside the control of the hospital (e.g., housing, food insecurity, social support, and transportation). Furthermore, Congress recognized that hospitals that disproportionately care for vulnerable patient populations, who are at a higher risk of readmissions, are disadvantaged when these factors are not considered in the payment scoring methodology and mandated that CMS adjust hospital readmission penalties for the proportion of dually eligible patients under the Hospital Readmission Reduction Program. CMS has implemented this adjustment through stratifying penalties by the proportion of Medicare and Medicaid dual- eligible patients the hospital serves. This stratification is only the first step toward accurate risk adjustment for patients with social and economic challenges. CMS must go beyond adjusting only payments to also adjusting the underlying measures in order to make accurate quality comparisons. One promising avenue for incorporating SDS factors into measure-level risk adjustment is the National Quality Forum (NQF)'s NQP Social Determinants of Health Data Integration Project which ensures that measure developers are improving measures currently in use by incorporating critical SDS data elements into measure risk adjustment when possible. The AAMC urges CMS to work with NQF on this effort.</p> <p>Remove PSI-90 from Star Ratings</p> <p>The AAMC has numerous concerns with the PSI-90 composite measure. Some of the components of the measure focus on surgical care, which disadvantages teaching institutions that tend to have a larger volume of surgical cases than do other hospitals. Further, the PSI-90 tends to penalize hospitals that have large volumes of surgeries, even where the probability of an adverse event is the same as a low-volume hospital.</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	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*
3/28/2019	Additional Comments on the Overall Star Ratings	<p>Additionally, some components of the measure are susceptible to surveillance bias and therefore institutions that are more diligent about reporting safety events are penalized^{2, 3}. For example, teaching institutions tend to have robust infection control programs, which focus on identifying and reporting patient safety events. Finally, the measure is based on administrative claims data so cannot capture the full scope of patient-level risk factors.^{4,5,6} While the modified composite may be an improvement over the previous version, many of the issues previously cited in comments to the Agency continue to apply, and because of this, CMS should remove the PSI-90 measure from the Star Ratings methodology</p> <p>Conclusion</p> <p>The AAMC welcomes engagement on these issues and appreciates the opportunity to comment. We look forward to continuing work with CMS on these issues. If you have any questions, please contact Gayle Lee at (202) 741-6429 or galee@aamc.org and Phoebe Ramsey (202) 448-6636 or pramsey@aamc.org.</p> <p>1 See National Academies of Sciences, Engineering, and Medicine. 2016-2017. Report Series: Accounting for Social Risk Factors in Medicare Payment. Washington, DC: The National Academies Press. Details here: http://www.nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx</p> <p>2 Koenig, Lane et al. Complication Rates, Hospital Size, and Bias in the CMS Hospital-Acquired Condition Reduction Program. American Journal of Medical Quality. December 19, 2016. Retrieved from: https://journals.sagepub.com/doi/abs/10.1177/1062860616681840.</p> <p>3 Blay Jr., Eddie et al. Evaluating the Impact of Venous Thromboembolism Outcome Measure on the PSI 90 Composite Quality Metric. The Joint Commission Journal on Quality and Patient Safety. March 2019. Retrieve from: https://www.jointcommissionjournal.com/article/S1553-7250(18)30220-4/pdf</p> <p>4 “MedPAC Comments on FY 2014 IPPS Proposed Rule.” June 25, 2013. Retrieved from: http://www.medpac.gov/documents/comment-letters/medpac's-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0</p>	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	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*
3/28/2019	Additional Comments on the Overall Star Ratings	5 Rajaram, Ravi et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. JAMA. Vol 313, No. 9. March 3, 2015. Retrieved from: http://jama.jamanetwork.com/article.aspx?articleid=2109967 6 Medicare's Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015. Retrieved from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142	Janis M. Orlowski, M.D., M.A.C.P. Chief Health Care Officer, Association of American Medical Colleges	galee@aamc.org	Professional Association	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Any quality rating system is only as good as its individual measures, especially one that combines all of these individual measures into a single composite rating. Unfortunately there remain several issues with the structure, reliability and validity of some of the individual measures.	Jennifer K. Carlson, Associate Vice President for External Relations and Advocacy; Ohio State University Wexner Medical Center	Jennifer.carlson@osumc.edu	Medical University	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Have you ever surveyed the public/general consumers of various demographics, to see if they use the Star Ratings and Hospital Compare site? Or are most hits to the website from existing hospitals and health systems, not consumers? Is the audience of the Star Ratings truly consumers, or are hospitals and health systems the ones who have become more obsessed with it? Can make case for this with user-customized ratings (based on who might use the feature) or out of scope (asking about previous patterns of use)..thoughts?	Linnea Huinker, Manager of Quality and Safety; North Memorial Health Hospital	linnea.huinker@northmemorial.com	Hospital	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	This analysis assumes that the rankings use measures that accurately reflect consumer priorities and preferences for seeking inpatient care. While we support a statistically sound method that results in more balanced measure loadings, we question whether the current measures reflect consumer priorities.	Jordan Russell, MPA, CPHQ, Director of Quality, Analytics & Performance Excellence, UnityPoint Health; Sabra Rosener, JD, VP, Government & External Affairs, UnityPoint Health	cathy.simmons@unitypoint.org	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*
3/29/2019	Additional Comments on the Overall Star Ratings	<p>CMS should publish a transparent and objective measure that assesses whether the star ratings are working as intended for both patients and health systems. There currently appears to be no published objective measurement that assesses if the star ratings are achieving what they are intended to achieve. Patient-level measures should at minimum include an assessment of how often Medicare beneficiaries are using the star ratings in health care decisions. Health system-level measures should at minimum include an assessment of how well health systems believe the star ratings reflect the true clinical quality of care provided at their hospitals. Creating these measures through fair process with patients and health systems would create a foundation for ongoing improvement in the star ratings themselves in the face of the dynamic landscape of healthcare provision in the United States.</p> <p>CMS should investigate additional strategies to make it easier for health systems to understand recent performance of peer institutions on meaningful clinical outcomes contained in the star ratings. The easier it is for health systems to identify higher performing systems that they can learn from, the more likely it is that lower performing systems will improve at a faster rate.</p>	Daniel Hoody, MD, MS, Chief Medical Quality Officer; Hennepin Healthcare	Daniel.hoody@hcmh.org	Healthcare System	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	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. Measures should be risk adjusted to account for socioeconomic and sociodemographic factors that complicate care for high risk patients.	Steve Harris, Vice President & Payor of Government Affairs, Tampa General Hospital	johnrothenberger@tgh.org	Hospital	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	<p>There are concerns about having PSI-90 as a composite score with the rating system. One of the concerns is the variance of surgical volume cases that may be present at larger facilities in comparison to smaller facilities. In theory, where there are the larger chances of something being adversely affected the likelihood of something will be affected. Larger institutions may have more complications in part to low volumes of cases at smaller institutes. There are also concerns of reporting integrity. Some facilities may not operate under quality programs that are more transparent and more likely to report safety events. Whereas, other facilities may be more honest in their reporting of safety events. This reporting integrity could inadvertently affect a facility while rewarding another for not reporting as accurately and transparently.</p>	Greg Pike RN, Quality Nurse Specialist II, Vidant Health Quality	GPike@vidanthealth.com	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*
3/29/2019	Additional Comments on the Overall Star Ratings	-Missing authoritative information: It is interesting that other programs much more suited for collecting meaningful performance such as the NSQIP surgical PI program do not find their way into the ratings. Others could be considered as well including NCDR registries, GWTG for Stroke, HF, etc. Put more time and effort into requiring hospitals to collect this standardized clinical registry data instead of calling the hospitals who actually spend the large amount of voluntary \$ on the best registries to look for improvement. Stop using data which is meant for billing as a gold standard to show quality of care when there is much more authoritative and accurate clinical registry data. Is it more expensive for hospitals to collect? Of course. Wouldn't it say a lot about which hospitals care about improving who spend the additional \$ to participate? CMS should be obtaining that data and including it into STAR RATING (NCDR, NSQIP, GWTG) when hospitals do participate, and those should be weighted much higher than the administrative billing data.	Todd Scrimet, MBA, MT(ASCP), Assistant Director, Quality Management; Albany Medical Center Hospital, Quality Management Dept.	scrimet@amc.edu		Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Mortality is the ultimate outcome in hospital quality. Using the current methodology, there are several hospitals which received 4 or 5 stars despite performing worse than the national average for the Mortality measure group. We believe the rating system should highly value mortality outcomes and not rate hospitals with worse than national performance as high quality.	Jeremy Boal, MD Chief Clinical Officer Executive Vice President Mount Sinai Health System; Vicki LoPachin, MD Chief Medical Officer Senior Vice President Mount Sinai Health System ; G. Troy Tomilonus Vice President, Clinical Decision Support Mount Sinai Health System	troy.tomilonus@mountsinai.org	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*
3/29/2019	Additional Comments on the Overall Star Ratings	<p>Regarding Severe Sepsis and Septic Shock</p> <p>The inclusion of the severe sepsis and septic shock measure (SEP-1) added to the Effectiveness of Care process measure group due to its introduction to Hospital Compare is a good idea. However, it would be realistic to separate measures instead of the current bundle. The bundle compliance is all or none. While all measures are important, the prior methodology used for HF, CP, SCIP, and PN was more realistic. Facilitating healthcare organizations to separate and bundles, easier performance improvement visualization, and setting national benchmarks for each measure.</p> <p>Regarding the patient safety indicators, we strongly agree with the PSI 90 being a focus point for HAI's. The PSI 90 include the following indicators.</p> <p>PSI 03 - Pressure Ulcer Rate</p> <p>PSI 06 - Iatrogenic Pneumothorax Rate</p> <p>PSI 08 - In-Hospital Fall with Hip Fracture Rate</p> <p>PSI 09 - Perioperative Hemorrhage or Hematoma Rate</p> <p>PSI 10 - Postoperative Acute Kidney Injury Requiring Dialysis Rate</p> <p>PSI 11 - Postoperative Respiratory Failure Rate</p> <p>PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate</p> <p>PSI 13 - Postoperative Sepsis Rate</p> <p>PSI 14 - Postoperative Wound Dehiscence Rate</p> <p>PSI 15 - Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate</p> <p>There are more indicators in the PSI 90 than the following six measures: CAUTI, CLABSI, SSI, MRSA bacteremia, and CDI measures. In addition, the indicators are heavily weighted on the surgical specialty.</p>	Carlos J. Cardenas, MD, Chairman of the Board, Doctor's Hospital at Renaissance Health	kkincaid@appliedpolicy.com	Hospital	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	<p>We would suggest that data to be measured and publicly reported should be proven to be relevant and accurate for the type of facility being measured.</p> <p>The reliability of each measure should be evaluated and if reliability is not demonstrated the measure should not be included in determining Star Ratings</p>	Amy Arnett, MS, RN, CPHQ, CPPS Quality/Infection Prevention Manager Horizon Health	aarnett@myhorizonhealth.org	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*
3/29/2019	Additional Comments on the Overall Star Ratings	We would like to request a review of the Overall Star Rating score for Geneva General Hospital, as we believe that the score does not accurately reflect the care that our patients receive.	Kathleen R. Reilly, B.S., RRT, CCMSCP Director, Quality and Performance Improvement Finger Lakes Health (Geneva General Hospital/Soldiers and Sailors Memorial Hospital)	Kathleen.Reilly@fhealth.org	Individual	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Under readmissions: The components of this measure that are three year rolling measures and lag behind by a year when rating are posted becomes a demoralizing measure to those who are working to improve readmission. The three year rolling metric means that improvement efforts will not be fully reflected in the star ratings for three to four years. I propose changing this measure to a one year measure for all readmission subgroups.	Diane C. Kantaros, M.D. Corporate AVP of Clinical Quality Health Quest	dkantaros@Healthquest.org	Individual	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Methodological Disclosure We urge CMS to consider adding a notice for consumers that Hospital Compare ratings are just one aspect to consider when selecting a health care provider. Reducing the numerous care teams and service lines provided by a hospital to a single five-star rating is a dramatic simplification of the many aspects that contribute to quality care delivery. The Joint Commission also suggests that CMS include an analysis of the cut points that distinguish each rating in addition to the overall rating distribution. In-group differences may appear misleading to consumers who do not understand the distinction between each rating.	Margaret VanAmringe, MHS, Executive Vice President for Public Policy and Government Relations, The Joint Commission	PRoss@jointcommission.org	Healthcare Performance Improvement Organization	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Add MSPB to measures. MSPB already is provided on Hospital Compare. Efficiency is a quality measure.	Dale N. Schumacher, MD, MPH, President, Rockburn Institute	dale.schumacher@rockburn.org	Healthcare Performance Improvement Organization	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	Additional Comments on the Overall Star Ratings	<p>Increase the weighting for mortality and reduce the weighting for safety and readmissions.</p> <p>Under the current methodology, many clinicians believe there remains a weighting bias – specifically that risk-adjusted mortality is under-weighted given both its clinical importance and its well-documented history as a valid, reliable quality measure versus patient safety, experience, and other metrics^{11,12}. For example, one important way that mortality differs as a quality metric is the virtually non-existent possibility of surveillance bias versus other metrics such as patient safety indicators (PSIs)¹³. Because of surveillance bias, hospitals which provide both high-quality care and reliable documentation may have artificially higher rates of PSIs simply because they are “looking harder” for these events¹⁴. Such bias does not affect mortality, as Medicare’s documentation of beneficiary deaths is widely considered to be valid, and regardless of hospital quality, an in-hospital death is quite unlikely to be missed by clinicians and documenters. Further, rarer complications/PSIs and hospital-acquired infections may occur very infrequently at low volume hospitals, so the precision of these estimates may vary widely based on volume and case mix, and two hospitals with quite different PSI rates may not differ statistically.</p> <p>Readmissions are also inherently less important of a quality metric than mortality, because in nearly all circumstances, a readmission is a better outcome than a death. In fact, many times a readmission is itself a positive outcome. For example, in the case of a “planned” readmission, a patient must have survived the index admission and continued following his or her plan of care until such time as the scheduled readmission occurs. Setting aside the superiority of mortality as a quality metric, it has been difficult to establish correlations between readmission rates other traits associated with high-quality hospital care, including volume and mortality¹⁵. There has been some success showing a correlation between lower readmission and better quality care among surgical patients¹⁶. On the other hand, a 2018 JAMA Cardiology study showed that among heart failure patients, lower 30-day readmissions after implementation of the Hospital Readmissions Reduction Program (HRRP) were accompanied by an increase in 30-day mortality¹⁷.</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	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*
3/29/2019	Additional Comments on the Overall Star Ratings	<p>One widely cited paper examined more than 100 studies to determine whether readmission rates were a valid measure of hospital quality¹⁸. The study examined several of the methodological and theoretical issues regarding the validity of readmissions, including unplanned versus planned readmissions, competing risks of death or other outcomes, coding practices, readmissions to (or from) different institutions, and uncertain care after discharge. The authors concluded that higher readmission rates were generally correlated with patient safety indicators, but there was substantial variation and it was inconclusive whether readmission rates formed a good overall quality metric. Given the relative ambiguity of readmission rates as a quality metric (especially in comparison to mortality), we further our recommendation that mortality be given more weighting in the CMS star methodology while the definitions and methodology behind the readmission rates should continue to undergo discussion and refinement.</p> <p>11. Jha AK. The Stars of Hospital Care: Useful or a Distraction? JAMA. 2016;315(21):2265-2266.</p> <p>12. Bilimoria KY, Barnard C. The New CMS Hospital Quality Star Ratings: The Stars Are Not Aligned. JAMA. 2016;316(17):1761-1762.</p> <p>13. Bilimoria KY, Chung J, Ju MH, et al. Evaluation of surveillance bias and the validity of the venous thromboembolism quality measure. JAMA. 2013;310(14):1482-1489.</p> <p>14. Kubasiak JC, Francescatti AB, Behal R, Myers JA. Patient Safety Indicators for Judging Hospital Performance. Am J Med Qual. 2017;32(2):129-133.</p> <p>15. Chen LM, Jha AK, Guterman S, Ridgway AB, Orav EJ, Epstein AM. Hospital cost of care, quality of care, and readmission rates: penny wise and pound foolish? Arch Intern Med. 2010;170(4):340-346.</p> <p>16. Tsai TC, Joynt KE, Orav EJ, Gawande AA, Jha AK. Variation in surgical-readmission rates and quality of hospital care. N Engl J Med. 2013;369(12):1134-1142</p>	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	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*
3/29/2019	Additional Comments on the Overall Star Ratings	17. Gupta A, Allen LA, Bhatt DL, et al. Association of the Hospital Readmissions Reduction Program Implementation With Readmission and Mortality Outcomes in Heart Failure. JAMA Cardiol. 2018;3(1):44-53. 18. Fischer C, Lingsma HF, Marang-van de Mheen PJ, Kringos DS, Klazinga NS, Steyerberg EW. Is the Readmission Rate a Valid Quality Indicator? A Review of the Evidence. Plos One. 2014;9(11).	John D. Poe, Chair, Quality and Affordability, Mayo Clinic	Schubring.Randy@mayo.edu	Health System	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Re-examine the value of the Hospital Readmissions Reduction Program (HRRP). Although it is a useful measure of utilization, the HRRP continues to fail rigorous evaluation of its value as a quality measure. Recent research has shown that hospitals with low readmissions tend to have high mortality rates, especially for conditions such as heart failure. Hospitals that keep people alive by readmitting them for complications should not be penalized for doing so.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report
3/29/2019	Additional Comments on the Overall Star Ratings	Change the way Hospital Compare displays star ratings. MHA urges CMS to consider changing how and where star ratings are displayed on the consumer-facing Hospital Compare website. The current way that the website repeats the overall star rating on every page gives the user the incorrect impression that the displayed star rating on the page refers to the specific metrics displayed on an individual webpage – but that is not the case. A hospital could be a top performer for mortality or readmissions, but if its overall rating is two stars, those two stars display on the pages that show highly favorable performance as well as pages with less favorable performance. This approach is misleading to the public and a nuance that the average member of the public may not recognize.	Patricia M. Noga, PhD, MBA, RN, NEA-BC, FAAN, Vice President, Clinical Affairs, Massachusetts Health & Hospital Association	KStevenson@mhalink.org	Hospital Association	Please refer to the Summary Report

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

Explicit Approach

Table 1. Rush University Medical Center-Safety Measures for CMS Programs

Measure	Overall Rating	HACRP	VBP
Central-Line Associated Bloodstream Infection	X	X	X
Catheter-Associated Urinary Tract Infection	X	X	X
Surgical Site Infection from Colon Surgery	X	X	X
Surgical Site Infection from Abdominal Hysterectomy	X	X	X
MRSA Bacteremia	X	X	X
Clostridium Difficile	X	X	X
PSI-90	X	X	X
THA/TKA Complications	X		
Elective Delivery Prior to 39 Completed Weeks Gestation			X

Table 2. Rush University Medical Center-Loading Factors for Safety Domain by Release

Measure	Feb 19	Jun 18 (Not Released)	Dec 17	Oct 17
Star	4	3	5	4
Central-Line Associated Bloodstream Infection (CLABSI)	0.01	0.02	0.02	0.03
Catheter-Associated Urinary Tract Infection (CAUTI)	0.007	-0.004	0.001	0.01
Surgical Site Infection from colon surgery (SSI-colon)	0.05	-0.04	0.05	0.05
Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)	0.07	-0.01	0.05	0.02
MRSA Bacteremia	0.04	0.03	0.07	0.08
Clostridium Difficile (C.difficile)	0.03	0.03	0.01	0.02
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
Patient Safety for Selected Indicators (PSI)	0.90	0.17	0.94	0.92

Figure 1. Rush University Medical Center-Feb 2019 Safety Domain score vs PSI-90 score

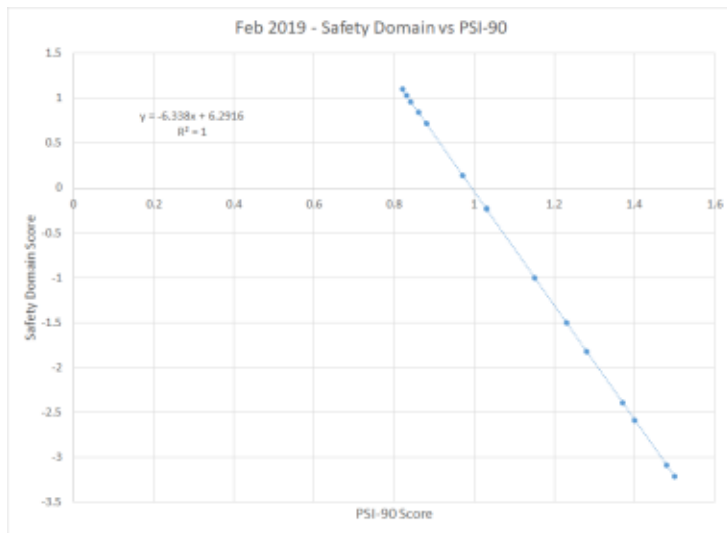
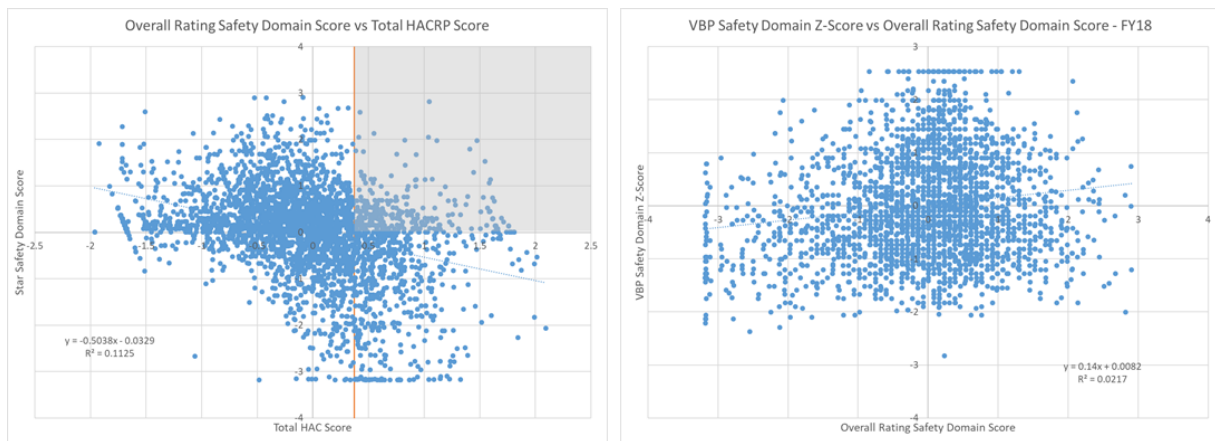


Figure 2a-2b. Rush University Medical Center-Correlation of Overall Rating Safety with HACRP and VBP Safety



Clustering Alternatives

Figure 3. Tahoe Forest Health System

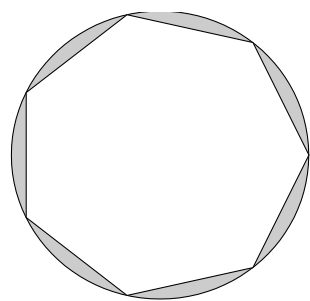


Figure 4. Tahoe Forest Health System-A Boat

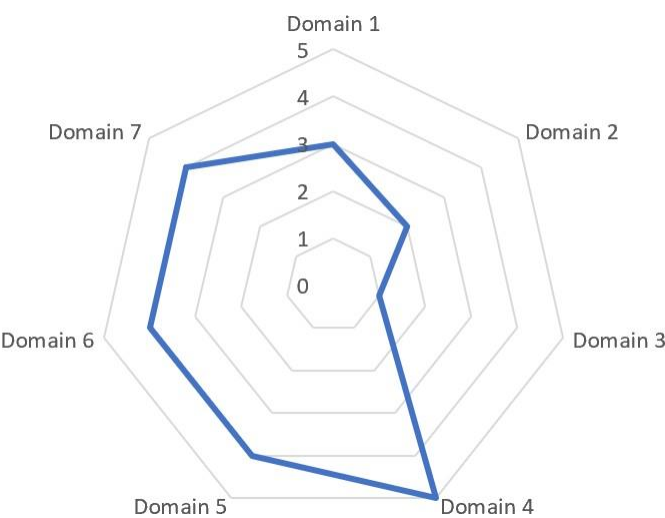


Figure 5. Tahoe Forest Health System

$$\frac{n \sin \left(\frac{2\pi}{n} \right)}{2\pi}.$$

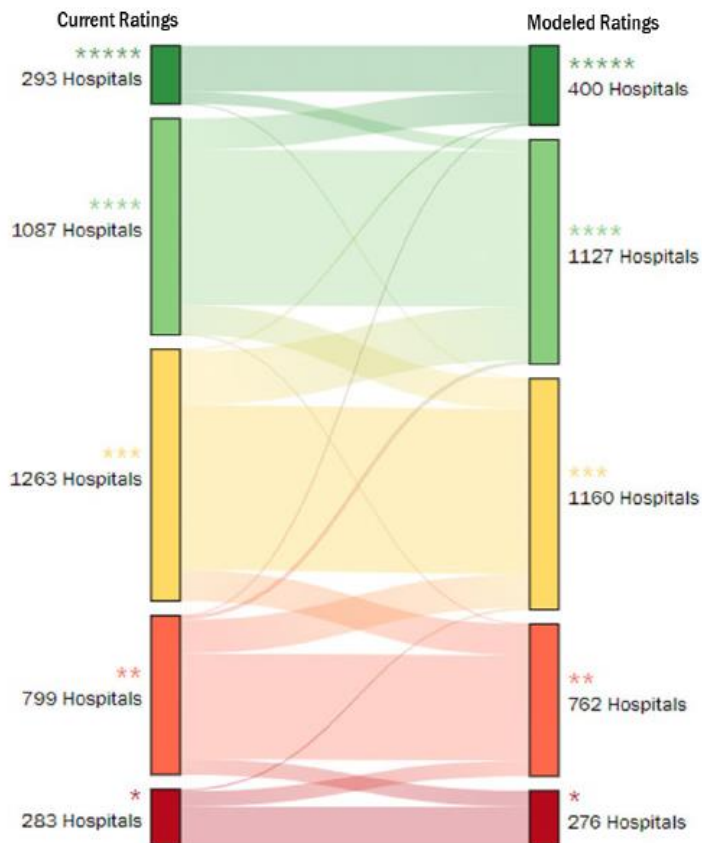
Figure 6. Tahoe Forest Health System

Interval	Star Rating
$[0, 0.1724052)$	1 star
$[.1742052, 0.3484104)$	2 star
$[0.3484104, 0.5226156)$	3 star
$[0.5226156, 0.6968208)$	4 star
$[0.6968208, 0.871026)$	5 star

User-Customized Star Rating

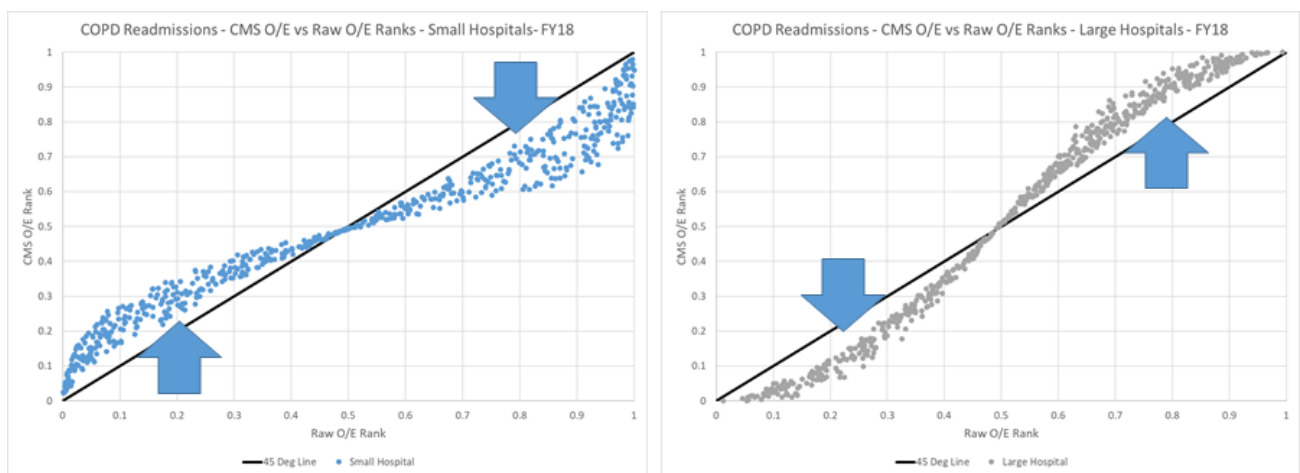
Figure 7. Healthcare Association of New York State

Estimated Change in Provider Ratings, Current Ratings vs. User Specification Scenario



Beyond the Scope of Star Ratings Project

Figures 8a-8b. Rush University Medical Center- Ranking Adjustments for COPD Readmissions by Hospital Size



Figures 9a-9e. Rush University Medical Center- CMS Readmission vs Raw Readmissions – By Hospital Size – Heart Failure

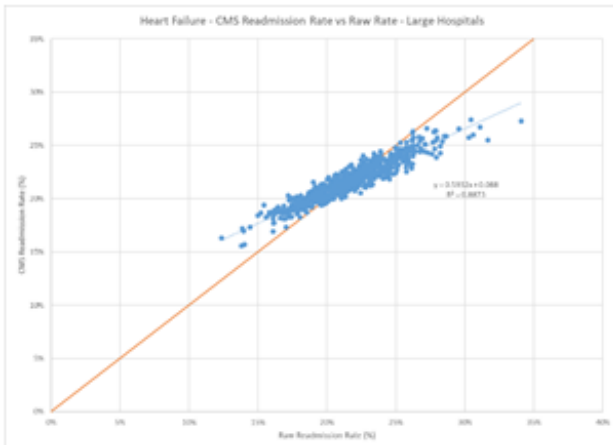
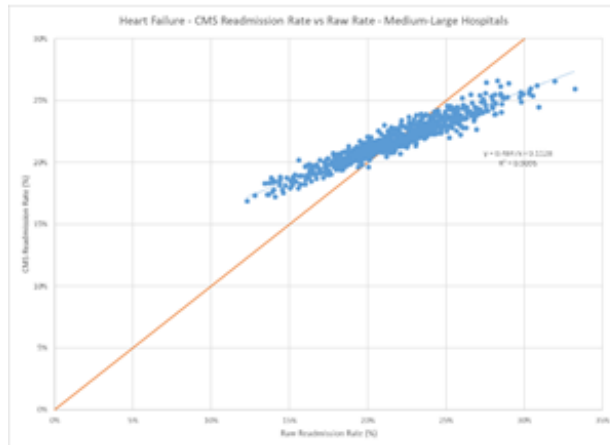
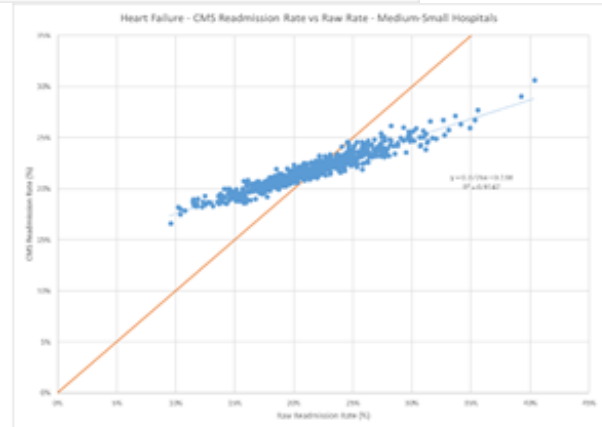
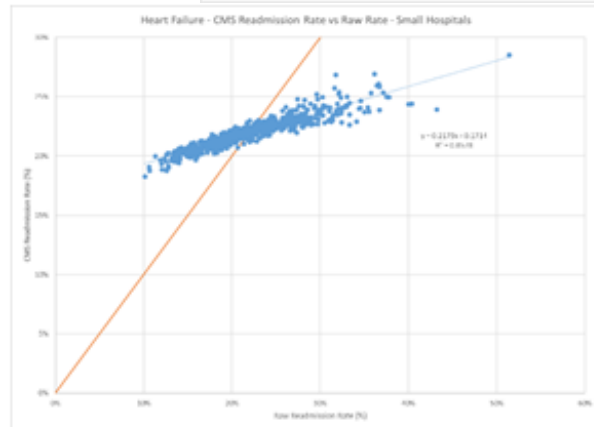
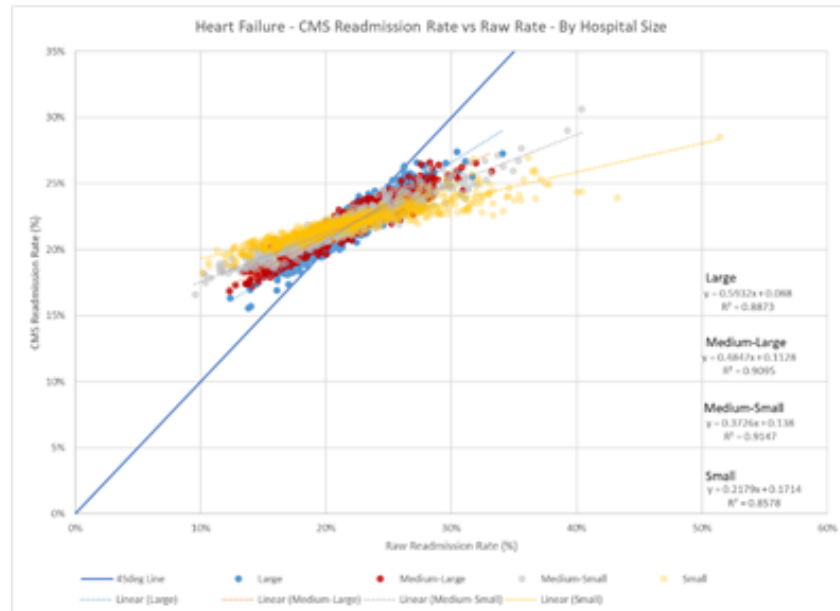


Table 3. Rush University Medical Center- Heart Failure Readmission Rates (July2013-June 2016)

Heart Failure	Large Hospital in Detroit, MI	Rush University Medical Center	Small Hospital in Texas
Discharges (3 years)	997	730	37
Raw 30-Day Readmissions (Rank)	25.8% (Bottom 15%)	27.8% (Bottom 10%)	43.2% (Bottom 1%)
CMS Corrected (Rank)	24.1% (Bottom 10%)	24.7% (Bottom 5%)	23.9% (Bottom 15%)

Figure 10. Rush University Medical Center- Volume and Acuity Correction of HF 30-Day Readmissions for small hospital in Texas

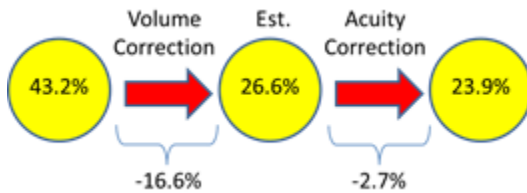


Table 4. Rush University Medical Center- Heart Failure Readmission Rates (July 2013 – June 2016) – Estimated

Heart Failure	Large Hospital in Detroit, MI	Rush University Medical Center	Small Hospital in Texas
Discharges (3 years)	997	730	37
Raw 30-Day Readmissions (Rank)	25.8% (Bottom 15%)	27.8% (Bottom 10%)	43.2% (Bottom 1%)
Only Comorbidity Corrected Estimate (Rank)	25.8% (Bottom 20%)	27.2% (Bottom 10%)	40.5% (Bottom 1%)

Table 5. Rush University Medical Center- Results from Readmission Domain from Dec 2017 Release

Readmission Domain	Large Hospital in Detroit, MI	Rush University Medical Center	Small Hospital in Texas*
HWR Denominator (1-yr)	5,221	6,022	457
HWR Rate	16.8%	15.9%	16.2%
Readmission Domain	-1.9795	-0.7991	-1.1680
Stars	1	5	2

Table 6. Rush University Medical Center- Distribution of Stars by Hospital Size

Star	Large	Medium	Small
1	11%	7%	0%
2	26%	20%	8%
3	25%	33%	44%
4	25%	32%	42%
5	13%	8%	6%

Additional Comments on the Overall Star Ratings

Table 7. Rush University Medical Center- Loading Coefficients for Readmission Domain – Feb 2019 Release

Measure Group	Measure ID	Measure Name	Loading Coefficient
Readmission	EDAC-30-AMI	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	0.34
Readmission	READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	0.32
Readmission	READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	0.55
Readmission	EDAC-30-HF	Excess Days in Acute Care after Hospitalization for Heart Failure	0.45
Readmission	READM-30-Hip-Knee	Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	0.41
Readmission	EDAC-30-PN	Excess Days in Acute Care after Hospitalization for Pneumonia (PN)	0.44
Readmission	READM-30-STK	Stroke (STK) 30-Day Readmission Rate	0.53
Readmission	READM-30-HOSP-WIDE	HWR Hospital-Wide All-Cause Unplanned Readmission	1.00
Readmission	OP-32	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	-0.01

Figure 11. Rush University Medical Center- Correlation between Readmission Domain Score and HWR Measure – Feb 2019 Release

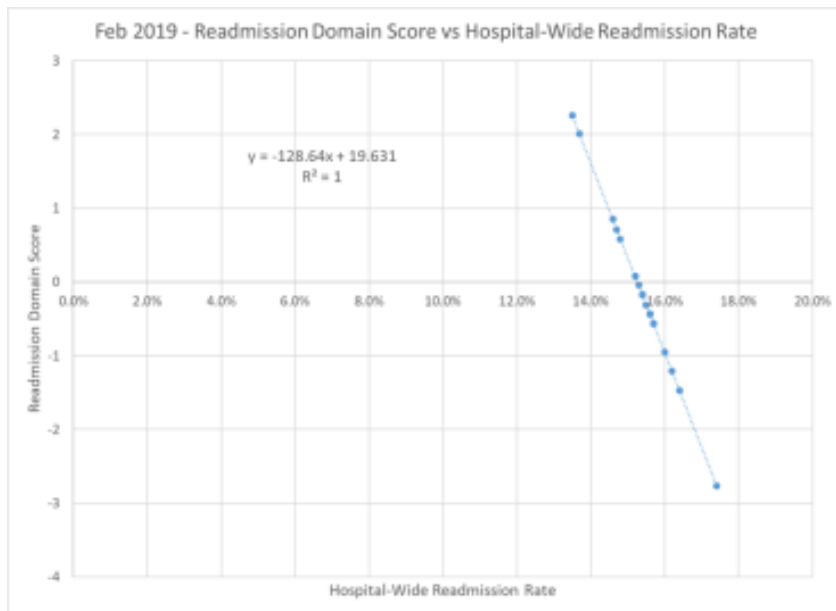


Figure 12. Rush University Medical Center- Histogram of Patients by Number of Readmissions

