

Centers for Medicare & Medicaid Services
National Call: Hospital Five Star Rating System
Moderator: Jill Darling
March 6, 2019
1:00 p.m. ET

Operator: Good afternoon. My name is (Lindsay) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services National Call on the Hospital Five Star Rating System.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Great. Thank you, (Lindsay). Good morning and good afternoon everyone and welcome to today's National Call on the Hospital Five Star Rating System. We appreciate your patience. I know we did not start on time but we're trying to get as many folks on as we could. So, thank you again for your patience.

This national call is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And so now, I will hand the call off to Michelle Schreiber.

Michelle Schreiber: Thank you and good afternoon. To those of you who are joining us on the phone, thank you for your interest. And we're delighted to be speaking to everybody today.

I'm Dr. Michelle Schreiber and I'm the Director of QMVG, which is the Quality Measurement and Value-based Incentives Group here at CMS.

QMVIG is the home of most of the quality measures of CMS as well as the value-based programs such as hospital stars, hospital value-based purchasing, MACRA, promoting interoperability, post-acute care, and others.

So, we're delighted to be talking about the update to the hospital stars program. As you know, the most recent version of hospital compare and hospital stars was released to the public in February after organizations had a chance in December to look at their preview data.

We have several new methodologies that were put in place this time to answer questions that arose at the last public release of this data. And Joe Clift who is also from the quality measures group and who is the expert on hospital stars will be picking up in just a few minutes to go through some of those details.

We've been listening carefully to stakeholders since the inception of the hospital stars program. And we certainly have heard some of the criticisms around the stars program. There are those who feel that there's a disadvantage to large academic centers. There are those who feel there may be a disadvantage to rural critical access hospitals. There are questions about social and economic determinants and how those play into risk factor adjustment.

The latent variable methodology is something that has been discussed as well as concepts of peer grouping, in other words, comparing like to like. So, as you also know, we put out a fairly extensive document that we'll be seeking public comment regarding many of these things and some of the thoughts about what a modernization of the stars program could potentially include. So, we are looking forward to receiving public comments over the next month.

With that, I'm going to turn this over to Joe Clift. Joe, I'll let you introduce yourself for a moment. And then, we will be taking questions later in the conversation. Thank you.

Joseph Clift: Great. Thank you very much and thank you everybody. I'm Dr. Joseph Clift. I'm a technical advisor at CMS.

So, like Dr. Schreiber said, the hospital compare and the star ratings was refreshed on February 28. The last public refresh of the star ratings was in December of 2017. And as many of you know, we did not refresh in July of 2018 after various stakeholders had expressed some concerns about their preview report and what they perceived as large swings, two or more star ratings, from their previous rating.

So, what CMS has done is we did not refresh the star ratings in July and we – July 2018. And we used much of the remainder of 2018 to hold a series of listening sessions and various stakeholder meetings with various hospitals and hospital groups, patient and consumer advocacy groups to learn what their concerns were about the star ratings methodology, what feedback did they have, et cetera.

So, what we have done for the February release is address two concerns that have come up previously dealing with the star ratings methodology. The first update for February is removing measures with statistically significant negative loading within latent variable model. And that is a simply a model input that if a measure does have a statistically significant negative loading that we would remove that measure for all hospitals. For February, there was no measure that had a statistically significant negative loading. So, that is again just a model input. There was nothing that was taken out as a result to that.

The second update that we did for the methodology was to bring in additional denominator data for the healthcare-associated infection measures. Previously, the healthcare-associated infection measures and the safety of care group, the denominator was the predicted infection which has a relatively small denominator.

Within the latent variable model, the model gives higher weight to measures that have larger denominators. And as many of you are aware, the PSI 90 measure is – get the most weight each time. And for many hospitals, that denominator is in the millions. So, that overshadows the healthcare-associated infection measures in terms of the loading.

So, what we did was bring in additional data elements that we have with those measures such as the patient's days, the number of procedures, and the device days to give more emphasis to those measures within the safety of care group.

And the result of that was that although the PSI 90 is still the highest weighted measure within that group, some of the HAI measures does have more weight within the safety of care group in February of 2019 as compared to previous. So, those were the updates for February 2019.

As (Michelle) alluded to on February 28, what we also did was release for public comment a series of updates that CMS is considering to the star ratings. And I just want to spend a little bit of time kind of going through some of those right now.

So, if we – the items that are in for public comment, we can kind of put them into two buckets. One is things that we could do in the near term, probably by the next refresh of star ratings, things that we can accomplish in the near term.

So, what we're seeking comment on is four main items; one, dealing with measure grouping. And this is trying to get stakeholder feedback on how CMS should consider measures to be grouped within the star ratings. And why is this important?

The reason this is important is because as a part of the meaningful measures initiative, we have a lot of measure that are moving out of programs, new measures being added. So, the current measures set that makes up the star ratings right now might not look what we might have in the future.

And are there other ways that we should consider grouping measures together? And that could be anywhere from measuring one group. We think it could be in another group or another idea that has come up is the PSI 90 for example. What if we broke out that PSI 90 into its 10 indicator components as opposed to one measure? We have 10. So, different things like that that we're seeking comment on.

The next thing that we're seeking comment on is incorporating measure precision. So, CMS is thinking of looking at ways that measures within each

group could be weighted differently. And this kind of gets at the, how could we address the issue that the PSI 90 and the safety of care group for example continues to be the highest weighted measure within that group.

So, are there things that we could incorporate into the model that kind of doesn't allow for one measure to overshadow other measures within the group. So, we have some things that we're considering. And that's in the public comment document that we're looking for comment on.

Another thing we're seeking comment on is other model inputs that we can make that deal with period to period shifts. So, this gets at what hospitals were concerned about in July of 2018 when they saw that their star rating might have gone up or down two or three stars since the last update.

Some of this has to do with if there's – within the model – it's not so much that there was a methodology change. But what we saw with July is that there was a significant measure change. And for July, that was switching from ICD-9 claims to ICD-10 claims for the PSI 90 measure.

So, are there things we can do within the model to help deal with some of these large period to period shifts that might – that hospitals might see when there are things like measure level changes taking place?

And the last sort of item that we're seeking comment on that we can address in the near term is what we're calling peer grouping. And this peer grouping can be a variety of things that we could potentially look at.

And this is getting at hospitals that have raised concerns that within the star ratings methodology presently, all hospitals are sort of lumped together in one data set. And then, a five-star rating is applied to all of those hospitals.

And what hospitals have said is we need to not have critical access hospital score, for example, be it – within the same data set, within the same category as maybe large academic teaching hospitals because they have more resources. They report on more measures.

The hospitals are fundamentally different. And we should come up with some type of peer grouping to put hospitals in these peer groups and then assign a star rating out of each peer group.

So, what we're seeking comment on it, what variables could we look at to peer group hospitals? Some things that have come up before are the number of measures that a hospital submit. So, for example, one peer group could be hospital that submit the bare minimum measures that get a star rating which is 9 to 15 measures. And another group could be 16 to whatever measures.

So, the idea behind that is to group hospitals in like categories based on the number of measures they submit. And the thinking behind that is that hospitals that are like smaller rural hospitals will submit fewer measures. And larger academic hospitals will submit the most measures. And this sort of de facto put them into more similar peer groups.

Other things that we are seeking comment on are potential variables such as teaching status or looking at the number of duals with dually eligible patients within the hospital population. So, what we're seeking comment on is what – should we do peer grouping? And if so, what is the feedback in the community about what variable we should do the peer grouping on?

The next set of items that we're seeking comment on – and these are more long term – changes we could make. These require a little bit more thinking, a little bit more analysis. But to give you a sense of that, what we're looking at is, is there a way to – what we're calling the explicit approach – is that where we could come up with weights for measures within a group, so predefined weights within a measure group alternatives to clustering.

So, right now, what we use is k-Means Clustering algorithm to determine a five star rating. Is there alternatives to this? Could we – if, for example, we were able to plot all hospitals on a number line and set predefined criteria of what is a one star? What is a two star? And if you're a hospital, met that number, you would be the star rating.

Things like incorporation of improvement. This is something where could we work within the methodology to give credit to a hospital that has improved.

So, for example, maybe at the last update a hospital was a two-star hospital. And then, the next update they were a four-star hospital. Could we incorporate some improvement aspect from going from a two-star to a four-star within the methodology?

In our dialysis facility compare, star rating does incorporate some method of improvement within their methodology. So, we're looking at, is there a way that we could do that? And what is the stakeholders' thinking on that?

What I will share is that for the incorporation of improvement, we have talked a little bit about this with some of our different stakeholder groups and particularly the patient and consumer groups were not really in support of this because they were really interested in seeing what is today's star rating based on the current data we have now, not necessarily how have they improved from before. So, we're seek – trying to seek a wide variety of comment on this particular enhancement that we could make.

And last thing we're seeking comment on, is there some way we could come up with a star ratings tool of some sort where a patient or a consumer could select from a predefined list of measures? Or, could they type in a condition and get a list of measures related to that? And then, have a user generated star rating.

So, for example, something that has come up where we might have a good number of measures for something maybe like a – something surgical like a hip replacement where we have measures for that. We have surgical-based patient safety measures. Is that something we could do and have a user generated star rating?

One of the things that we've heard from some stakeholders specifically about this and that's why we want to seek some comment on this. And why this requires a little bit more thinking and can be done in the near term is for a lot of things CMS doesn't have a measure for everything. And also, patients and consumers might not know if they're going in for this surgery or they have this illness that they should select these particular measures to get a star rating about that.

So, that's why this is on the list of something where need a little bit more thinking on but wanted to see what stakeholder input is for this. So, this public comment period closes on March 29th. So, we are widely broadcasting this information. This public comment period has been in many press articles. It has gone out on CMS's various Listserv to reach a wide audience.

We have shared it with our stakeholder groups and encourage them to disseminate that we are expecting a large response to this call for public comment. And sort of our next steps are after the public comment period closes, we have a support contractor that will help us go through all of the comments that we received.

And we'll kind of organize them by the different topics that I talked about and get a sense for what the public supported for something, feedback from the public, and then use that to inform our decision making for potential updates to the star ratings methodology for the next update.

Related to that, I did want to share that also in the public comment period; we do have mentioned that CMS is thinking of possibly going to an annual refresh of the star ratings. Currently, we do a twice a year. So, we are seeking public comment on the possibility of moving to a once a year star ratings update.

We have heard anecdotally support from different provider communities about this, not so much support from patient and consumers because that group of stakeholders generally wants more data, more frequent updates instead of less.

So, again, what we're trying – what we at CMS are trying to do is get as much public comment we can on the star ratings methodology, get a wide variety of public comments. Often, what we had found through the listening sessions and talking to stakeholders is that even within members of the provider community there is not always agreement on what we should do.

The provider community often differs from what the patient and consumer community wants. So, CMS, we have a tough line to walk to make sure that we are responsive to stakeholder concerns, whatever they are, as well as trying

to stay true to the intent of the star ratings, which is to summarize hospital quality information for patients and consumers.

So, in closing, I'll say we hope everybody on this call provides comment. We are looking forward to that comment. And we do appreciate the support and any feedback that you have with the star ratings. And that will conclude what I had to share today.

Michelle Schreiber: So, this is Dr. Schreiber. And before we open this up for questions, just a couple of final comments to Joe's. And Joe, thank you for a great explanation.

We all need to remember that the main purpose of the star rating is exactly what Dr. Clift outlined and that's for patients – for patients and consumers to be able to understand aspects, especially quality and safety of healthcare so that they can make informed decisions.

We recognize this has also become an important tool for hospitals and healthcare organizations to look at their performance and be able to compare it to others especially the national level. And that hopefully, this is promoting continuous quality of improvement within those organizations.

I will say from personal experience in organizations and from what we hear from other stakeholders, this has done that. It has generated many examples of continued performance improvement. And frankly, through public reporting, we have seen certainly lots of examples of improved quality and safety of our healthcare across America.

With that, I guess we have the opportunity to open to questions. (Jill) and (Lindsay), I will let you lead us into that.

Operator: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And our first question comes from the line of (Joyce Messenger) with Medicaid Services. Your line is now open.

(Joyce Messenger): No. I have no question.

Operator: And our next question comes from the line of Candace Eden with Advent Health. Your line is now open.

Candace Eden: Yes. Good afternoon. The question that we had is associated to the (healthcare)-acquired infection measures and with movement from going from using the number of predicted number of infection which is a summary risk adjusted metric if you will to back to using the number of device days or procedures if you will or patient days, which is not risk adjusted.

Could you speak a little bit about – and very much do appreciate the fact that it does help with the weighing process considering the denominator data for the PSI 90 is much, much higher. But the concern is, when looking from a risk adjusted measures to a non-risk adjusted measures, when you're comparing facilities that are not equally demographically the same even within the location.

So, can you speak a little bit about how statistically have you been looking at that and maybe even considering just separating these two denominators are not the (same) (inaudible) ratio to the raw denominator (data)? Thank you.

Joseph Clift: Yes. This is Joe. So, for the modeling – the latent variable model, we're still using the SIR for the hospital for their HAI measures. What we've brought into in addition to that is the added data for the patient days, the devices days or the number of procedures into the model to give more – to give more weight to those, the HAIs.

But the HAIs are still – the risk adjusted SIR that – data that CMS gets from the CDC. It's like an additional input into the model to give more weight to those. So, we're not altering the measure itself to – from a risk adjusted to a non-risk adjusted measure.

It's additional input within that measure to give more weight to those measures since the issue within the model is that measures with larger

denominators are not going to get as much weight. I mean, are going to get more weight.

So, what we're trying to do is add an additional component to that. But it's still the same risk adjusted SIR that is what the hospital is based on for the rating.

Candace Eden: Thank you.

Operator: Our next question comes from the line of (Vallie Anderson) with Hiram Davis Medical. Your line is now open.

(Vallie Anderson): Thank you. I tuned in to listen. I'm not even quite sure if I'm on the right call. But I'm calling to try to get some ideas to the – listen to try to get some ideas to how the quality measures are going to work out for us? We're a small, 60-bed facility that we deal primarily with ID population and some mental health. So, therefore, our skilled rehab short stay numbers are low. So, we keep having the risk adjusted for the denominator less than 20. And we've gone from being a five-star facility to a four-star facility. And it's like almost impossible for us to be able to get that star back.

So, it's like we feel like we're being kind of penalized for being small. How does that work out to kind of even the playing field for us so that we're not showing up on the five-star rating in a way that does not really represent who we are?

Joseph Clift: Hi. This is Joe. Thank you for that question. That has come up many times for us especially with small hospitals. And that is one of the reasons we have some of these items up for public comment that hopefully can get some of these issues that we're hearing from hospitals such as maybe number of measures, peer grouping having – comparing hospitals that look more similar to each other instead of all hospitals together.

So, that is something that we are looking at. And you'll see that in the public comment document.

(Vallie Anderson): OK.

Michelle Schreiber: And this is Dr. Schreiber. I would just comment that as we look at the results of stars rating, there is pretty much an equal distribution between small hospitals and large hospitals of the proportion of one star, two stars, three stars, et cetera.

And so, there doesn't appear to be a tremendous difference in very small hospitals compared to large hospitals in terms of the distribution of the stars rating. Joe, you can correct me if I misspoke.

Joseph Clift: No, that's correct.

(Vallie Anderson): So, I thank you for that. And I will share that for the group at large. We did try to take upon us – the really proactive assault on our QM. And we were so excited to get our fifth star. And the very next rate, it was gone.

So, I understand that there'll be some up and down going forward. And basically to my understanding, you're not seeing a great deal of disparity among the smaller facilities and that perhaps the peer grouping might be something coming down the line that would help to make it more equitable overall.

Michelle Schreiber: Correct.

(Vallie Anderson): OK.

Michelle Schreiber: Thank you.

Operator: Our next question comes from the line of Disha Kothari with St. Joseph Healthcare. Your line is now open.

Disha Kothari: Hi. Thank you for the updates. I just wanted to know – initially, you said that as a new update, we're moving with – moving out of the statistically significant negative loading. So, could you please elaborate more? And how is – what exactly – can you explain more on that?

Joseph Clift: Yes, thanks for that question. So, when CMS runs the latent variable model and has all the measure data within it as a statistical output of the model, a

measure could have a negative loading. And basically, what that means for a hospital is if you are looking at a hospital that – a measure has a negative loading and you're looking at a hospital that maybe did very well, maybe they did very well on that measure, but the measure itself has a negative loading within the model.

That hospital it's like a higher number times a negative number which gives you a more negative number versus a hospital that didn't do very well on that measure then they have like a lower score times a negative number. They have a less negative number.

So, in terms of quality, a negatively loaded measure – the hospital – a hospital that performs worst on that measure actually comes out better when you're looking at that measure.

So, the idea is that if a measure has a statistically significant negative loading, we need to take that out because it's unfairly penalizing hospitals that will – that have performed well on that measure. And if we do take a measure out that meets that criteria, it will be out for all hospitals within that star rating's update.

Disha Kothari: OK.

Joseph Clift: Did that answer your question?

Disha Kothari: Yes, it did. Thank you, Joe.

Joseph Clift: Sure. Thank you.

Operator: Our next question comes from the line of (Maggie Sparks) with Bear Lake Memorial. Your line is now open.

(Maggie Sparks): Hello. So, I did have a comment on the star rating. We're critical access hospital. And we've been in the top 100 critical access hospital for the last two years and have also been recognized this year again. And we've been in the top 20. Last year, we got two awards.

However, where we're at if we don't have a star rating. Our discharge numbers to provide a star rating is low. We're recognized for quality but yet for the star rating we're not recognized. So, is that also being considered to look at, the size of the hospital, the number of their patients, and – so, that we are also allowed to get a star rating on what we do?

Joseph Clift: Yes. Thank you for that question. So, the – so, some of the variables that we're seeking comment on and if you look through the public comment document and you think of others that we had not considered in that, please feel free to add those to your public comment response.

But we have set for reliability and validity reasons a bare minimum number of measures to get a star rating. And that is three measures in a group – at least three groups and one group has to be an outcomes group.

So, you theoretically could get a star rating with nine measures. One thing that we've heard from hospitals is that they might get the bare minimum number of hospitals that they had one patient that with an extra infection or an extra re-admission or two and that sort of put them out. And they felt that that star rating is not reflective of the care that that hospital gives.

And so, there's a lot – we're trying to do a lot of thinking about within this peer grouping is how we can address this. But one of the things that is bare minimum is just having enough measured data where it's a reliable and valid data from a hospital to give a star rating. So, that's why we have nine measures at the bare minimum.

And I know that within the critical access community hospitals that in December of 2017, I think it was about half – it's about the same each time, about half critical access hospitals get a star rating, the other half don't. The half that don't usually it's because of their – they don't have enough measured data or that they're not participating and/or – and submitting measured data as they're voluntarily in the hospital programs.

So, we're trying to do is get some public comment from the – especially from the critical access hospital community. We do hear that a lot one star rating

and they can't get one. They just don't meet the measured criteria. And then, the ones that do get one, we often hear that they feel that it's not meaningful for them.

So, that's – we're trying to – you'll see that in the public comment ways that we're trying to address that.

(Maggie Sparks): OK. Thank you.

Joseph Clift: You're welcome.

Operator: Our next question comes from the line of Trina Abla with Penn State Health. Your line is open.

Trina Abla: Hi. Thank you for taking my question. My question refers to the reporting time frame for the various metrics starting with mortality going back as far as July 1st of 2014. Looking for some insight as to why the reporting frame goes back so far? And when we might look at advancing that so that the star rating is more reflective of our current status as opposed to what it was five years ago?

Joseph Clift: Hi. This is Joe. Thank you for that question. I do have to pull up another document – I apologize – to look at all the periods. So, for a lot of our measures, some measures have – and I think this might be what you're getting at – some measures have a longer look back period.

Trina Abla: Correct.

Joseph Clift: Is that what you're – yes. So, that is a function of how that measure was developed and the rationale for including that look back period. But as each – as we move forward, the data for those, it has occur – a more current period. But the look back period is – for some of these are two or three years. It sort of looking like a five-year period for maybe some of these measures.

So, as that goes forward, that five-year period gets more current. But that is just how that measure was developed and the rationale for why, it included that look back period.

Trina Abl: Do we know when they will be – I'm sorry. Go ahead.

Joseph Clift: And then for – I'm sorry. No, please go ahead.

Trina Abl: I was just wondering if when they would be moved forward. For example, I know that in the most recent release, it was the same reporting timeframes as the previous non-released data. And where we're looking toward in six months moving all of those reporting timeframes ahead six months?

Joseph Clift: I have to look and see if that might be a measure that generally refresh. So, that's why it wouldn't have been a change from the July but would have been a change from the December.

So, a lot of our measures that we publicly report on hospital compare some measures are an annual update, refresh of the data, and some measures are quarterly and we have some measures that are updated twice a year.

Trina Abl: OK. So, the ...

Joseph Clift: Yes. For like the PSI 90, for example, that's a July update. So, what you're seeing in – what you saw in your December preview report for the February release was the same data period and the same – the same score for the PSI measure that you saw in July which is different from what you saw in December.

Trina Abl: OK.

Joseph Clift: Because that annually updated in July.

Trina Abl: Got it. So, for that one, it was October 1st of 2015 to June 30th of 2017. And we could anticipate for the following year that it would be October 2016 to June 30th 2018?

Joseph Clift: I believe so. But I have to double check on a measure list. But I believe that's correct. It goes up a year.

Trina Abl: OK. Great. Thank you.

Joseph Clift: You're welcome.

Operator: Our next question comes from the line of Jordan Shapiro with BJC. Your line is open.

Jordan Shapiro: Hi. Thank you. I was just wondering if you could comment on the current status of incorporating any kind of adjustments for social determinant for health or social risk factors and the star rating.

Joseph Clift: This is Joe. So, one of the things we are seeking comment on is the – is there a way we can address that through possibly peer grouping. I will say that related to this and CMS hears a lot of this concern about lack of risk adjusting for SES, SDS, whatever you want to call it, there's a variety of opinions on how this can be accomplished and how it should be accomplished.

And we have heard varying opinions that this is something that should be done at the measure level and incorporated into the star ratings as such if that measure has a risk adjustment for social risk factors.

We have heard from other stakeholders that the star rating should have some type of adjustment for that within the star ratings methodology. We have heard from other stakeholders that they think that should not be anything that the star ratings itself deals with that it should again only be with the measures. And there's not even universal agreement on what measures should have that.

For things like re-admission measures, we've heard that those might be more of a prime candidate for some – for risk adjusting for social risk factors. And then, we have heard from others that there are other measures in the star rating that feed into the star ratings that should not have that such as the healthcare-associated infection measures for example.

So, I would encourage anyone to if they have comments on this or feedback to please submit that through the public comment and that's really what we're trying to see is what the public thinks about how CMS should address this.

Jordan Shapiro: Thank you.

Michelle Schreiber: And this is Dr. Schreiber. I'd just like to piggyback on Joe's comments.

This is a topic that is discussed heavily at CMS about how to look at social risk. And I think part of the challenge even is how do we define it? How do we collect the appropriate data on social risks?

So, if you wanted to weigh in on that in your comments, we would appreciate that. But it is something that is being considered. And there are multiple points of view.

Jordan Shapiro: Great. Thank you.

Operator: Our next question comes from the line of (Laurel) (Inaudible) with Kaiser. Your line is open.

(Laurel): Thank you. Good morning. My question is related to peer grouping. And so, our hospital, we don't see a lot of Medicare Fee for Service patients. It's a small patient population. And many of the measures are driven by this patient population.

So, when you consider peer grouping, are you making any consideration about payer sources?

Joseph Clift: So, for the peer grouping, we don't have specifically have something related to that. For a lot of the measures, the measure – for a lot of the measures that we have as you know are – many are 65 and older. A lot are for fee-for-service beneficiaries.

A lot of the measures are 18 and over. And we do know that there is within the Medicare beneficiary population, a lot of beneficiaries are on Medicare Advantage Plan. And for many of our measures, probably all of our measures, we – those within a claims-based measure – that population is not part of it. Is that what you were trying to get at is those beneficiaries? That might be – you'd might have more in your state or in your community that might be Medicare Advantage?

(Laurel): Yes.

Joseph Clift: Yes. So, we do know that that is a gap. And there is – for a lot of the measures that – the claims-based measures, CMS does not have access to all of the data element needed for measure calculation that we do for the fee-for-service. That is something that we are looking into. But for right now, the claims measures are the fee-for-service.

(Laurel): OK. Thank you.

Joseph Clift: You're welcome.

Operator: Our next question comes from the line of Theresa Edelstein with New Jersey Hospital Association. Your line is now open.

Theresa Edelstein: Good afternoon and thank you for this afternoon's call. It's been very helpful. Just a comment how the star ratings get used that may or may not have been part of the thinking behind it. We certainly understand that this is primarily a consumer tool. And we support anything that helps consumers choose their healthcare providers in a more transparent way. But we also see across the board with the five-star rating not just for hospitals that payers use these ratings to obtain at times leverage in contract negotiations or to make decisions about network inclusion.

So, I think while not the primary intent of your comment period, this is something that as changes are being considered that realistically has to be taken into consideration and perhaps just view through that lens as stakeholders contribute their thoughts to how the star ratings process might be improved. Thank you.

Michelle Schreiber: Thank you. This is Dr. Schreiber. We're certainly well aware and have heard multiple examples of that across many states actually that payers are using this for many times network inclusion.

It's one of the reasons that we are seeking comments to consider modernization of stars. Again, the intent is truly for consumers and we are committed to that. But we want to make sure that we've taken in other stakeholder considerations in particular that the star ratings are as fair and

accurate as possible because we recognize that although it is not the intent of the stars program, it is being used in some cases to this end.

So, we appreciate your comments. And feel free to send further suggestions that aren't perhaps outlined in the request for information if you think that there are other things that would be helpful in this.

Theresa Edelstein: Thank you.

Operator: And as a reminder ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad.

Our next question comes from the line of (Von Frick) with (Ashbeck LLC). Your line is now open.

(Von Frick): Thank you. Joe, I think this question is for you. There's a couple of things. I want to make sure something doesn't get lost in the discussion here. There's really two objectives. You've got a latent variable model that's predictive in nature. And basically, we're trying to predict the performance of hospitals in the future.

I think what a lot of consumers are also interested in and anybody that's running a continuous process improvement program is going to want to make sure they have unadjusted actual performance data.

There's basically two objectives that you need to try and sort through here. I mean, obviously, the predictive model is going to be very important for hospitals and their marketing departments. But the people who are trying to do performance improvement need to have that actual data. Are we going to be able to make sure that both of those objectives are met?

Joseph Clift: Hi. Yes, this is Joe. Can you elaborate a little bit more on your question? Are you – is it that you think that there's data that is not available but should be?

(Von Frick): Well, I think we're moving towards a star rating system here that's not so much a grade for past performance as it is a prediction of future performance.

And I mean, no matter how careful you try and do things like risk adjustments and so forth, it's going to be an imperfect model.

And so, I'm worried that by trying to do the predictions, we're going to lose the actual data – the unadjusted data.

Joseph Clift: OK. Yes. I think what – I mean, what would be beneficial to CMS is if you have ideas of what could look like so that we could consider that I think that would be a valuable comment for us. I unfortunately don't have a whole lot more to say on that.

We often hear from hospitals that some of our measure data is a little old for what we're rating as today's rating. Some of this data might have had a data period for a year or two ago. We're not at that sort of real-time data aspect right now. But this has come up before.

Some of our data – there's our – the time we get the claim then and all the claims are mature, there is a lag for that data, the CDC. We get data from them. There's a lag from when that data closes to when we use it for our programs. So, if you have ideas, I think that would be really helpful for us to be able to consider and weigh in more.

(Von Frick): I would be happy to help. That's all I have.

Operator: Our next question comes from the line of Jill Robinson with Hennepin County Medical Center. Your line is now open.

Jill Robinson: Good afternoon sir. Thank you much for taking my call. My concern is that our particular facility got our star rating down much further than we wanted it to be because of a reason that has nothing to do with the quality of care we provide. We were told that we submitted incomplete information; and therefore, it's kind of like we got an F for not submitting our homework.

Is there some way to reflect that information was incomplete rather than giving us something (inaudible)?

Joseph Clift: At the – at the present time, no, there's not. So, we use the data that we have on hospitals and assume that the data that the hospitals have submitted including the claims that they have submitted are accurate and true.

With various programs, there's an attestation component that the hospitals attesting that the data is accurate and complete and that is what we view.

Jill Robinson: Yes. We were told, however, that our data was inconsistent. So, we feel like we are penalized for things other than our actual quality of care.

Joseph Clift: Yes. I think for your particular question to maybe dig a little more into your particular situation. If you go to our quality net website and use the quality net help desk, they might be able to provide a little bit more information to your specific circumstance.

Jill Robinson: OK because our doctors are working their tail for us and our results we feel we absolutely do not reflect what they do but the fact that our information wasn't consistent. It's more like submitting a paper than (actions) than rather the real results of our researcher – real results of what we're doing. It didn't really reflect what we're really doing. So, anyhow, thank you for the suggestion.

Jill Darling: And (Lindsay), we'll take one more question please.

Operator: Our last question comes from the line of Candace Eden with Advent Health. Your line is now open.

Candace Eden: Hello. Earlier, Joe you talked about the potential of using a consumer rating where they could actually rate with stars by some specific criteria. If we do that, how would you incorporate it into the star rating? And would you remove some of the HCAPHS data? What were you thinking about that?

Joseph Clift: So, thank you for that question. What we're – this particular idea is very new and very fresh and that's why we're trying to seek comment on what actually could look like. So, as you'll see in the public comment document, we have a few ideas that we thought about but this is one of the ones that requires a lot more thinking about how this could actually be rolled out and materialize.

And if it's something we should do. And that's what we're seeking comment on. So, if you have ideas of what it could look like, what it should look like, we're open to those.

Candace Eden: Great. Thank you.

Jill Darling: And Joseph or Michelle, do you have any closing remarks?

Michelle Schreiber: I think just in closing first of all to all of you on the call thank you very much and thank you Jill and (Lindsay) for being great hosts and Joe obviously for your expertise.

I do want to assure everybody that at CMS we actually do read every single submission and are looking forward to everybody's comments. We will take them to heart and try and weigh all of the various stakeholder input as we consider our deliberation around the hospital stars rating.

Once again, with the emphasis on the consumers, which is who this is really for. So, thank you for participating today.

Operator: This concludes today's conference call. You may now disconnect.

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