

December 14, 2017

HOSPITAL COMPARE UPDATE TO INCLUDE NEW STAR RATINGS, HAC PAYMENT PENALTIES

The Issue:

On or about Dec. 20, the Centers for Medicare & Medicaid Services (CMS) will likely update its *Hospital Compare* [website](#) with new star ratings and release the list of hospitals receiving Hospital-Acquired Condition (HAC) penalties for fiscal year (FY) 2018. Corrections to the star ratings calculations likely mean that significantly fewer hospitals will receive a three star rating this year than last. As a result, many more hospitals will receive four or five stars, while additional hospitals will receive one or two star ratings. In the past, release of the HAC payment penalty list and the star ratings have generated media attention. This *Quality Advisory* will help you prepare your organization for the public release of the star ratings and HAC payment penalties.

Background:

In July 2016, CMS began to report hospital quality star ratings on *Hospital Compare*. To determine the ratings, CMS combines performance on over 50 measures into a single rating of one to five stars (with five stars being best). The ratings were last updated in December 2016.

Since their inception, the AHA has raised significant concerns about the accuracy and validity of CMS's star rating approach. In 2016, we joined with other national hospital [associations](#) and the majority of [Congress](#) in asking the agency to delay the release of star ratings until the problems in the execution of the methodology were corrected. We also noted many concerns regarding the methodologic approach CMS had chosen, questioning whether it created an easy-to-understand and accurate assessment of hospital quality.

For this month's release, CMS and its contractor have corrected errors in how their chosen methodology was executed, but they have not yet begun to address concerns regarding the appropriateness of the underlying approach. We continue to work with CMS to improve its approach to star ratings. If your hospital has received a lower star rating, the [attached talking points](#) should be useful in assisting you and your staff in preparing to respond in case you get press calls, or need to address this with your board or other community leaders.

Additionally, since 2015, CMS has imposed a HAC payment penalty on those hospitals in the lowest-performing quartile for a small set of infection measures and a patient safety indicator derived from claims information. Since the inception of this program, the AHA has noted the many problems with these calculations, including the fact that the methodology and choice of measures seem to particularly disadvantage both small hospitals and those serving the most complex patients. The AHA continues to work with CMS and the National Quality Forum to ensure improvements in the measures and methods to help address these problems. Substantial improvements in this program, however, will require changes to the underlying law that established it. If your hospital is on the list of hospitals receiving HAC payment penalties for FY 2018, you may need to publicly address this, and the attached set of [talking points](#) will be helpful as you prepare to do so.

Our Take:

The AHA is pleased that CMS and its contractor have corrected errors in their previous star rating calculations. However, we remain concerned that an overall hospital star rating oversimplifies the complexity of care delivery and is over-reliant on a set of measures that are flawed and were never strategically chosen to create an overall single star rating that is a reliable and representative assessment of hospital quality. In addition, the HAC payment penalty is poorly designed and significantly biased against those that both treat the most complex patients and are small with relatively few patients whose care fits in the measures.

What You Can Do:

Please share this advisory with your chief quality officer, clinical leadership and media relations team.

- ✓ Ask them to review the final methodology on the *Quality Net* website and discuss your organization's star rating, which has been available to you in a confidential preview report on *Quality Net* for the past 30 days. The preview period ends today.
- ✓ Determine if your hospital is receiving a HAC payment penalty this year. You should have received notice of this penalty from CMS prior to Oct. 1 and your payments should reflect the 1 percent penalty.

- ✓ Review the [attached talking points](#) and tailor them to your particular organization.
- ✓ Gather information about the quality and safety improvement efforts you have underway so that you can be prepared to speak to the work you are doing to ensure safe and effective care in your organization.

Further Questions:

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Talking Points CMS Star Ratings

Background:

In July 2016, CMS began to report hospital quality star ratings on [Hospital Compare](#). To determine the ratings, CMS combines performance on over 50 measures into a single rating of one to five stars (with five stars being best). The ratings were last updated in December 2016.

Since their inception, the AHA has raised significant concerns about the accuracy and validity of CMS's star rating approach. In 2016, AHA joined with other national hospital [associations](#) and the majority of [Congress](#) in asking the agency to delay the release of star ratings until the problems in the execution of the methodology were corrected. The AHA also noted many concerns regarding the methodologic approach CMS had chosen, questioning whether it created an easy-to-understand and accurate assessment of hospital quality.

For this month's release, which is expected on December 20, CMS and its contractor have corrected the majority of errors in how the chosen methodology was executed, but they have not yet begun to address concerns regarding the appropriateness of the underlying approach. Corrections to the star ratings calculations mean that significantly fewer hospitals will receive a three star rating this year than last. Many more will receive four or five stars, while some more will receive one or two star ratings. We continue to work with CMS to improve its approach to star ratings.

Talking Points:

- **Hospitals were pioneers in quality measurement, and have shared safety and quality data with the public for more than a decade** because patients and their families need clear, meaningful information to make health care decisions.
- **When making health care decisions, patients should use all available tools at their disposal** such as talking with friends and family and consulting with doctors, nurses and other health care providers.
- **(Insert name of hospital) is committed to quality and safety.** In fact, we are pleased that over the past few years, we have Insert data demonstrating a significant improvement in quality or safety you hospital has made).
- While it may be well intentioned, **the CMS star ratings program is confusing for patients and families and raises far more questions than answers.** These ratings have also been broadly criticized by quality experts and Congress as being inaccurate and misleading to consumers.

- **The updates to this round of star ratings corrects some errors, but do not fix the fundamental problems with the approach.** 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. Thus, arbitrary choices of measures and methodology have far too much impact on how a hospital is rated.
- **We continue to urge the agency to remove the star ratings from its website and not to republish them** until it can create a more sound approach that outside experts have reviewed and agreed is executed correctly.
- As longstanding supporters of transparency, **the AHA is committed to continuing the dialog with CMS about the goal we share -- providing the public with accurate, meaningful information about quality.**

General Talking Points on Transparency/Score Cards

- **CMS is one of a number of organizations that provide reports and rankings of hospital performance.** As with any report cards or ratings, each must be interpreted in context, and it is unlikely any one report card will provide a robust and reliable portrait of quality in a hospital. For example, some of the data used to calculate hospital grades can be years old, and may not reflect more recent performance improvement efforts. In addition, not all measures apply to all patients, which can matter when report cards are used as the primary tool to select a hospital for a specific procedure. Also, the proliferation of scorecards means that hospitals often receive divergent ratings across different reports, even when the reports are based on some of the same measures.
- **Variation among numerous reports and rankings of hospital performance has caused confusion for health care professionals and patients.**
 - To address these concerns, national hospital associations – the AHA, the Association of American Medical Colleges (AAMC), America's Essential Hospitals, Catholic Health Association (CHA), Children's Hospital Association and the Federation of American Hospitals (FAH) – have all endorsed a set of principles for evaluating publicly reported provider performance data.
 - The principles are the result of an expert panel convened by the AAMC, and call for quality reports to be well-defined in purpose, for performance measure methodologies to be transparent and for measures to be valid.
 - To access the document, visit: <http://aamc.org/publicreporting>.

Talking Points HAC Program

Background:

On December 20, 2017, the Centers for Medicare & Medicaid Services (CMS) is expected to release on its *Hospital Compare* website the final list of hospitals that are incurring penalties under the Hospital Acquired Conditions (HAC) Reduction Program during federal fiscal year (FY) 2018. The HAC Reduction Program imposes a one percent reduction to Medicare inpatient payments for hospitals in the worst performing quartile (25%) of risk-adjusted national Hospital Acquired Condition (HAC) rates. Affected hospitals were informed by CMS that they would receive a penalty in the fall of 2017, and are being penalized for discharges on or after Oct. 1, 2017.

For FY 2018, hospital performance in the program is determined using six measures split into two measurement domains. One domain, which comprises 85 percent of a hospital's score, includes five healthcare-associated infection (HAI) measures – central line-associated blood stream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSIs), Methicilin resistant staphylococcus aureus (MRSA) infections, and *Clostridium difficile* (C. Difficile) infections. The remaining 15 percent of a hospital score is determined by a Medicare claims data-derived Patient Safety Indicator composite measure (PSI 90) that combines performance on several safety indicators, such as pressure ulcers, post-operative hip fractures and post-operative blood clots.

Talking Points:

- **America's hospitals are deeply committed to keeping patients safe. We support programs that effectively promote patient safety improvements. And we're improving.**
 - According to HHS, hospitals generated a **21 percent decline in many hospital-acquired conditions (HAC) between 2010 and 2015. That translates to 125,000 lives saved and nearly \$28 billion in health care costs averted.**

- **At (ININSERT NAME OF HOSPITAL) , we have been working diligently to reduce infections and improve safety by**
 - (Insert two or three examples of how your hospital has improved safety in the past 3 to 5 years.)

 - **Hospitals have enthusiastically participated in the Hospital Engagement Networks (HEN), and Hospital Improvement and Innovation Networks, which harness the collective focus and action of hospitals across the country. Results have been impressive. For example, the first HEN avoided more than 92,000 hospital-acquired conditions and has saved more than \$988 million in avoided health care costs between January 2012 and November 2014.**

- **Unfortunately, the HAC Program is a poorly designed policy that unfairly penalizes hospitals that care for the sickest patients.**
 - Penalties disproportionately impact the nation’s teaching and large urban hospitals.
 - These types of hospitals tend to have sicker patients and perform more complex surgeries.
 - The HAC program’s methodology scores hospitals only on those measures for which they have sufficient data.
 - When the hospital has too little data, the CMS methodology substitutes the average performance for the hospital’s specific performance on a measure. This puts larger and teaching hospitals at a disadvantage because they are more likely to have data for each measure and tend to treat a sicker patient population.
 - It can also disadvantage small hospitals whose performance is tied to only a small number of metrics, providing a narrow characterization of patient safety.
 - A recent [article](#) written by AHA staff and others in the *American Journal of Medical Quality* reviews some of the inherent biases in the HAC Program.

- **In fact, hospitals may even be punished in the HAC program for improving performance.**
 - For example, many HAI reduction efforts correctly focus on reducing the use of central lines and urinary catheters. However, the HAI rates could remain high because the measure denominators (i.e., days that patients are on central lines and catheters) become smaller.
 - A better design for this type of program is embedded in the Value-Based Purchasing (VBP) program and in using better measures. It more effectively promotes continuous progress on quality by rewarding both a high level of performance and significant improvement.

- **Even CMS agrees some of the measures do not truly capture hospital performance, especially for hospitals that care for patients with complex health needs.**
 - According to a 2012 analysis commissioned by CMS, many of the individual components of the composite Patient Safety Indicator (PSI 90) measure fail to reliably capture hospital performance.
 - Because of inadequate risk adjustment in the PSI 90 measure, hospitals may score worse simply because of their complex patient mix. That fails to accurately portray hospital performance.
 - Additionally, PSI 90 is calculated using claims data, which 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 inexact. For example, the PSI pressure

ulcer measure (PSI 3) relies on physician documentation to calculate rates, but the most detailed information on pressure ulcers often comes from nursing notes. That makes the measure ineffective.

- **By law, 25 percent of hospitals will always face HAC penalties regardless of improved performance. And that's wrong.**
 - By law, the program must impose penalties on 25 percent of hospitals each year.
 - So even if the hospital field as a whole achieves strong performance, one quarter of all hospitals will still be subject to payment reductions.
 - And if an individual hospital significantly improves its performance from one year to the next, it may still be subject to a penalty if it falls in the bottom 25 percent.
 - That would be like a college professor deciding that – at the beginning of a semester – 25 percent of the students in his or her class would fail, regardless of how well they do.

- **HAC penalties are arbitrary because they do not reflect meaningful differences in performance**
 - Recent research shows that over half of all hospitals have performance that cannot be distinguished statistically from the penalty threshold level.

- **We want the HAC program to stop unfairly penalizing hospitals.**
 - The program should not disproportionately penalize those hospitals serving the sickest among us.
 - The current law needs to be reformed to more effectively promote improvement.
 - And better measures are needed that accurately reflect performance on important issues.