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March 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

I am writing on behalf of the University of California Health System, known as UC Health, to share our medical centers' concerns with the Hospital Compare quality metrics methodology that determines individual hospitals' Star Ratings. UC Health is comprised of five preeminent academic medical centers located at UC campuses in Davis, Irvine, Los Angeles, San Diego, and San Francisco. Each UC Health medical center fulfills the roles of being a tertiary or quaternary care provider and safety net provider. UC Health's medical centers provide a broad array of medical services, including, but not limited to: trauma services, burn care, organ transplants, and advanced stage cancer care. Our medical centers, along with the myriad primary and specialty care clinics that they operate, make up much of California's healthcare safety net. As many as 60 percent of the patients treated by UC Health System are publicly insured or uninsured.
UC Health's medical centers continue to be ranked among the top medical centers in the country by many respected sources for the broad range of quality health care services they provide. We express great concern that the current Star Ratings methodology does not accurately reflect the heightened quality of care each of our medical centers provides. This is largely because the methodology fails to account for the vast array of medical services provided by UC Health's medical centers along with the high acuity patients and vulnerable patient populations our medical centers disproportionately serve. We continue to doubt that the methodology informing current Star Ratings can fulfill CMS's intended goal of providing patients with reliable information upon which to make informed decisions about the selection of a hospital. We are grateful for this opportunity to provide CMS with feedback on our long-standing concerns with the Star Rating methodology, along with the agency's proposals concerning incorporating measure precision, frequency of Star Ratings reporting, peer grouping, and User-Customized Star Rating.

UC Health's Star Ratings Methodology Concerns

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

Measure Precision

UC Health recognizes that the current Star Ratings methodology employs measure denominator weighting to account for differences in measure score precision, so that hospitals and measures with a larger denominator are more heavily weighted in each Latent Variable Modeling (LVM). This results in hospitals being scored more heavily on measures that include more patients in the denominator. As academic medical centers that are uniquely tertiary and quaternary care providers, with the use of the LVM method, the measures most heavily weighted for UC Health and our peers reflect the higher complexity services and higher acuity patients we typically treat in comparison to community hospitals, which are many patients' first point of care. For example, a community hospital is likely to be more heavily weighted on a pneumonia measure given it is the appropriate setting for treating more patients suffering from pneumonia. As leading academic medical centers and safety net providers for California, we have larger denominators for measures associated with the more complex medical services we provide These complex services include, but are not limited to, providing organ transplants, performing complex surgeries, providing burn care, and providing life-sustaining treatment to many patients suffering from advanced stage cancer.

UC Health does not think an "apples to apples" comparison can be made between the measures for which our medical centers have the highest denominators and the measures by which non-teaching hospitals or non-safety net provider hospitals have the largest denominators. We have

expressed concern that the current Star Ratings methodology rewards community hospital settings by omission. In other words, the measures for the medical services they either do not perform, or perform very little, provide little to no weight in their overall Star Rating component score. However, by virtue of being both safety net providers and last points of care for some of the country's sickest patients, UC Health's five academic medical centers have great weight attributed to many of the measures representing the complex medical conditions which they uniquely treat. Given the reality that across our system 60 percent of our patients are publicly insured or uninsured, weighting by large denominators cannot be near precise without also including much social-risk adjustment for the sociodemographic factors unique to the vulnerable populations our hospitals typically treat. CMS states that it has surveyed the current Overall Hospital Quality Star Rating measures and found that those in the outcome groups of Mortality, Readmission, and Safety of Care include some adjustment for precision by accounting for volume in the score itself, while measures in the four remaining measure groups of Patient Experience, Effectiveness, Timeliness, and Imaging Efficiency have no such adjustment. We request that social-risk adjustment for patients' sociodemographic factors must occur across all of these measure groups.

Reducing Frequency of Star Ratings Methodology Refresh

We appreciate CMS's interest in reducing the number of times per year the Star Ratings process is refreshed. Stakeholders have expressed concern that large shifts in the rating can be observed over a six-month period, and that it can be difficult to explain changes in the rating despite observing relatively modest changes in a hospital's performance on individual measures. UC Health sees benefit in providing an annual refresh schedule for the Overall Hospital Star Rating versus a biannual refresh. This would have the benefit of allowing for a change in a hospital's rating to be more clearly attributed to observed changes in the hospital's performance for the underlying measures.

In addition to addressing the frequency of a Star Rating refresh, CMS needs to make the data collected more relevant to consumers. Much of the quantitative data that feeds into the Star Rating are two years in arrears. It would be more reflective of the evaluated hospitals' current statuses if more contemporaneous data was applied to derive hospitals' Star Rating (i.e., data no older than 6 months).

Peer Grouping

UC Health urges CMS to calculate and present Overall Hospital Quality Star Rating results in a way that compares hospitals of a similar type, that treat similar populations, to each other. We think so-called peer grouping better accounts for the distinctions of various hospital types, as well as better informs consumers of what to expect from a given hospital. As earlier referenced in this letter, the mission of a teaching hospital, and in turn the population it is prepared to treat, is wholly different from the mission and work of other hospital types. We think peer grouping will result in less confusion for consumers and patients. We would request that academic medical centers be segregated from other hospital types when comparing quality metrics data and calculating a hospital's Star Rating. We also think consumers and patients will better understand the nature of UC Health's roles as teaching hospital, safety net and tertiary and quaternary care provider by assigning it to a peer group with other teaching hospitals, as well as specifically

teaching hospitals that see a high percentage of patients dually eligible for Medicaid and Medicare. Our peer academic medical centers have also previously requested that we be compared to each other and segregated from being viewed against other non-academic medical center hospitals whose Star Rating is published on the Hospital Compare Website. We would request that in addition to being compared to other peer academic medical centers, our Star Ratings be presented on the Hospital Compare website alongside with other academic medical centers' individual Star Ratings.

User-customized Star Ratings

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.

Our Chief Medical Officers and Chief Nursing Officers regret that CMS did not consider the full impact of releasing updated Star Ratings to assessed hospitals before publishing them this past month to the broader public. The Star Rating methodology includes layers of analytic complexity that limit a healthcare system or individual clinician's ability to communicate the actual meaning of a Star Rating in a thoughtful and clinically relevant manner. We worry that patients may be unnecessarily frightened or confused by a hospital's Star Rating, when our UC Health medical centers have repeatedly proven, with the corroboration of countless, respected quality experts and quality assessments, that they are leaders in providing high quality medical care. Many UC Health patients necessitate tertiary and quaternary services for which there are either few or no other alternatives available.

We believe that CMS should put into effect the following recommendations to ensure the Star Ratings methodology more accurately reflects the sophisticated, high quality care and more vulnerable patient populations commonly treated at UC Health's five academic medical centers.

UC Health's Star Ratings Methodology Recommendations

1) 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.

2) Allow for adjustment of socio-demographic factors of patients for the Star Ratings system's measure groups.

3) Apply Star Ratings on a peer group basis, so that hospitals are compared to similarly situated hospitals. A great flaw of the existing methodology is that academic medical centers cannot, and should not, have their quality metrics directly compared with other categories of hospitals, like community hospitals, which have totally different functions. By virtue of our teaching, research, and safety net missions, UC Health and our academic medical center peers routinely treat more highly acute and vulnerable patient populations than community hospitals.

Since the Hospital Compare Star Ratings system's inception, UC Health has sought to help inform the methodology CMS uses to assess hospitals' quality of care. We welcome ongoing discussions with the Yale quality experts tasked to review and revise the Star Ratings methodology. We do not believe the public can benefit from accessing CMS's Hospital Compare Star Ratings unless and until the methodology being used to evaluate hospitals more fully accounts for the distinct functions and patient populations characteristic of academic medical centers. Please refer questions any questions about our comments to Julie A. Clements, JD, MPP, Director of Health and Clinical Affairs in UC's Office of Federal Governmental Relations (julie.clements@ucdc.edu/ (202)-974-6309).

Sincerely,

John Stobo, MD
Executive Vice President