CMS Overall Hospital Quality Star Rating

Karla Weng, MPH, CPHQ

Michigan Center for Rural Health
October 21, 2020

1

Stratis Health

- Independent, nonprofit, Minnesota-based organization founded in 1971
  - Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Work at intersection of research, policy, and practice
- Long history of working with rural providers, CAHs, and the Flex Program
- RQITA is a program of Stratis Health

2

Rural Quality Improvement Technical Assistance Center (RQITA)

- Cooperative agreement awarded to Stratis Health starting September 2015 from the Health Resources and Services Administration Federal Office of Rural Health Policy (HRSA FORHP).
- Improve quality and health outcomes in rural communities through TA for FORHP quality initiatives
  - Flex/MBQIP
  - Small Health Care Provider Quality Improvement Grantees
- Focus on quality reporting and improvement

3

Overview

- History and context for the Centers for Medicare & Medicaid Services (CMS) Overall Hospital Quality Star Rating
- Review methodology changes proposed in the 2021 Outpatient Prospective Payment Systems (OPPS) Rule
- Discus impact of the proposed changes for CAHs

4

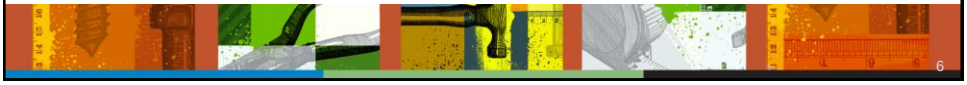
Why Star Ratings for Hospitals?

- CMS has stated that the objective of the Overall Hospital Quality Star Rating project is to summarize information from existing measures on Hospital Compare in a way that is ***useful and easy to interpret for patients and consumers***.
- Overall Hospital Quality Star ratings followed CMS release of Star Ratings across a variety of health care provider types, and release of the HCAHPS Star Ratings.

5

Overall Hospital Quality Star Ratings

- CMS started releasing Overall Hospital Quality Star Rating (Star Rating) on the Hospital Compare website in July 2016, earlier release was delayed due to Congressional pressure
- Summarizes *current* Hospital Compare measures across different areas of quality into a single star rating
- Although methodology has been tweaked, and the measures included change over time, more than 20% of hospitals consistently don't meet the threshold to have a rating calculated
  - The majority of those without a star rating calculated are small rural hospitals including CAHs.
  - Continued concern about the ratings, primarily focuses on the lack of risk adjustment and that the ratings may be misleading to consumers.



6

Current Threshold for a Star Rating

To have an overall hospital quality star rating calculated, must have a minimum of 3 measures in at least 3 groups, 1 of which must be an outcome group:

- Mortality
- Safety of Care
- Readmission
- Patient Experience
- Effectiveness of Care
- Timeliness of Care
- Efficient Use of Imaging

Source: Star Rating Methodology report: https://www.qualitynet.org/inpatient/public-reporting/overall-ratings/resources#tab3
Current Measures Included: https://www.medicare.gov/hospitalcompare/Data/Measure-groups.html

7

Star Rating and CAHs

- CAHs that have agreed to have their quality data publicly reported on Hospital Compare (nearly all CAHs) have always been included in the Star Rating calculations and received a rating if they met the measure threshold.
- For quality star ratings posted in January 2020:
  - 646 of 1350 CAHs have a rating calculated
    - ★★★★★: 55
    - ★★★★: 330
    - ★★★:225
    - ★★: 35
    - ★: 1

8

Proposed Changes to Star Rating Methodology

- CMS held a wide variety of stakeholder meetings and 'listening sessions' in 2019
- Significant changes to the overall methodology for Star Rating calculation have been proposed as part of the 2021 OPPS Proposed Rule (link below)

https://www.federalregister.gov/documents/2020/08/12/2020-17086/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

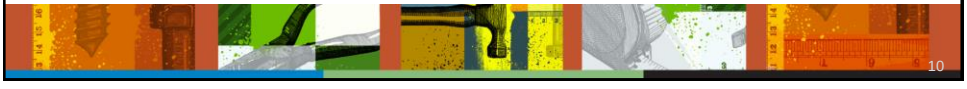
9

9

Proposed Changes (1)

- Shift from seven measure groups to five:
  1. Mortality (death rate for a variety of patient groups)
  2. Safety of Care (HAIs and complications)
  3. Readmissions (readmission rates, hospital return days)
  4. Patient Experience (HCAHPS)
  5. Timely and Effective Care
     (Consolidates process measures from Effectiveness of Care, Timeliness of Care, and Efficient Use of Medical Imaging Groups)
- Reflects overall direction of CMS to move away from process measures

Note: This section of the proposed rule includes what we believe to be a typo indicating: *the proposed new grouping would allow approximately 157 additional CAHs, beyond the **1,149** CAHs already receiving a star rating with the current methodology, to receive a star rating.*



10

10

Proposed Changes (2)

- Threshold to have a star rating calculated continues to be at least three measures in at least three measure groups – but one of those groups must be Safety of Care or Mortality

  (Currently needs to be to be Safety of Care, Mortality, OR Readmissions)

11

Proposed Changes (3)

- Simplification of statistical method to calculate measure group scores:
  - Currently complex using latent variable modeling and Winsorization
  - Proposed method shifts to simple average of measure scores within each measure group
- Stratify the Readmission group score by proportion of dual-eligible patients
  - If the information is available to CMS, hospitals that are not part of Hospital Readmissions Reduction Program (including CAHs) will have their readmissions score stratified based on the proportion of dual-eligible patients (aligning with the HRRP stratified groups).

12

Proposed Changes (4)

- Use a peer grouping approach to developing Star Rating 'cut-points'
  - Hospitals with three measure groups
  - Hospitals with four measure groups
  - Hospitals with five measure groups
- Intent is to address concerns about comparability of hospitals with fundamental differences such as size, volume, patient case mix, and service mix

13

Why the focus on CAHs in the proposed rule?

- Removal of the Notice of Participation process for the Outpatient Quality Reporting Program, which means that any OPPS measures submitted are automatically publicly reported
- Confirms that since CAH reporting is voluntary, they may have their Overall Start Rating withheld from public release if they submit a timely request (but due to proposed updated methodology CAH data will still be available in the public use data file)
- Proposal to use peer groups in the new methodology is not feasible if CAHs are not included.

14

Impact of proposed changes on CAHs

If all the proposed changes were applied to current data:

- Approximately 120 fewer CAHs will have a rating calculated
  - Increased number of CAHs meet the threshold of three measures in three measure groups due to the consolidation to 5 measure groups, but CMS continues to remove rural-relevant process measures
  - However, very few (if any) CAHs meet the 3-measure threshold for Safety of Care, so CAHs have to meet the 3-measure threshold for Mortality to have a rating calculated.
- There will continue to be more CAHs with four or five stars than with one or two stars, but a slight increase in the total number of 1 star, 2 star, and 5 star CAHs.

15

Comments? Questions?

Karla Weng,
Senior Program Manager
Stratis Health
952-853-8570 or 877-787-2847
kweng@stratishealth.org
www.stratishealth.org

16

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1RRH29052, Rural Quality Improvement Technical Assistance Cooperative Agreement, $625000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

StratisHealth Rural Quality Improvement Technical Assistance

17