



## Hospital Inpatient Quality Reporting (IQR) Program

### Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

#### Overall Hospital Quality Star Ratings: April 2026 Refresh Presentation Transcript

##### Speakers

**Ron Kline, MD, FAAP**

Chief Medical Officer, Quality Measurement and Value-based Incentives Group  
Center for Clinical Standards and Quality, CMS

**Arjun K. Venkatesh, MD, MBA, MHS**

Project Director

Yale New Haven Health Services Corporation/  
Center for Outcomes Research and Evaluation (YNHHS/CORE)

**Eve Rothenberg, MSHA**

Project Coordinator, YNHHS/CORE

**Cameron Gettel, MD, MHS**

Project Lead, YNHHS/CORE

**Kyle Bagshaw, MPH**

Subject Matter Expert, YNHHS/CORE

**Dawn Beard, LPN**

Clinical Analyst II, Star Ratings Lead, Lantana Consulting Group

##### Moderator

**Donna Bullock, BSN, MPH, RN**

Lead, Hospital IQR Program  
Inpatient and Outpatient Healthcare Quality Systems Development  
and Program Support

**January 28, 2026  
2 p.m. Eastern Time**

**DISCLAIMER:** This presentation document was current at the time of publication and/or upload onto the websites. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; this information will remain as an archived copy with no updates performed.

Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

**Donna Bullock:** Good afternoon, and welcome to today's event: *Overall Hospital Quality Star Ratings April 2026 Refresh*. My name is Donna Bullock. I am with the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support team. I will be your moderator for today's event. Before we begin, I would like to make a few announcements. If you registered for today's event, we emailed you a link to the slides a short time ago. If you did not get this link, the slides are available on the Quality Reporting Center website. That's [www.QualityReportingCenter.com](http://www.QualityReportingCenter.com). Also, during this event, you can download the slides by clicking the Handouts link. This webinar is being recorded. The recording and transcript of the event will be available on the Quality Reporting Center website and on the [QualityNet website](#) in the near future. This event has been approved for continuing education credit. More information will be provided at the end of the presentation.

Our speakers today include Dr. Ron Klein, Chief Medical Officer of the CMS Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality; Dr. Arjun Venkatesh, Project Director of the Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation; Eve Rothenberg; Dr. Cameron Gettle; and Kyle Bagshaw, all of the Yale New Haven Health Services Corporation/ Center for Outcomes Research and Evaluation; and Dawn Beard of the Lantana Consulting Group.

These are the members of the Overall Star Ratings team.

This is the agenda for today's event.

This slide includes acronyms and abbreviations that may be used in today's webinar. I will now turn the presentation over to Dr. Klein.

**Dr. Ron Klien:** Good afternoon, everyone. Thank you very much for joining the National Provider Call. We appreciate how busy everyone is and that you've taken time out of busy days to join us. We think this is an important topic and happy to discuss it.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

CMS views the input and feedback you give us as very, very important, and we're happy to listen as well as share our thoughts with you as well. So first, CMS continues active surveillance of the measure landscape through public reporting measures that are being consistently introduced and retired from public reporting as CMS continues to develop and add new measures to Care Compare, as we have in this refresh. Last year's 2025 Overall Star Rating release marked the third release in which VHA hospitals were eligible to receive star ratings. This refresh reflects the first implementation of a methodology update to emphasize the importance of patient safety to CMS within the star ratings program. This is aligned with other CMS initiatives to promote patient safety across payment, reporting, and quality improvement efforts. These changes were informed by substantial stakeholder engagement over the last three years where several meetings were held to discuss potential methodology changes to emphasize the Safety of Care measure group to align with CMS's focus on patient safety. This culminated into a Request for Information included in the 2025 OPSS proposed rule and a formal proposal in the 2026 OPSS proposed rule. Additional feedback was considered through these rule public comments, resulting in the methodology change emphasizing Safety of Care that was subsequently finalized in the 2026 OPSS final rule. CMS anticipates continued stakeholder engagement through multiple channels, providing hospitals and other stakeholders with meaningful opportunities to contribute to the ongoing evolution of star ratings. So, once again, I will thank you for your time today, and we'll look forward to the conversation.

**Eve Rothenberg:** Thank you, Dr. Klein. Hi, everyone. My name is Eve Rothenberg, and I'm the project coordinator for the STAR Ratings team at CORE. Today, I'm going to be sharing some general background of the Overall Star Rating project before we discuss the methodology and 2026 results.

For those who are familiar with the Overall Star Rating, you may recall the objective of the project. That is to develop a methodology to summarize quality measure information published to Care Compare on Medicare.gov in a way that is useful and easy to interpret for patients and caregivers.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Similar to the objective, the guiding principles of the project have remained consistent since the introduction of the Overall Star Rating about 10 years ago. Throughout the past several years, we have used methods that are scientifically valid. We have a team of statisticians and analysts that are continuously ensuring the accuracy and representativeness of the Overall Star Rating results. We also ensure those methods are inclusive of hospitals and measure information published on Care Compare on Medicare.gov, as well as the heterogeneity of available measures and hospital reporting. Additionally, we strive to accommodate changes in the underlying measures that comprise the Overall Star Rating results. We aim to be aligned with Care Compare on Medicare.gov and other CMS programs, as well as be transparent with our methods. We accomplish this through release of methodologies annually, in addition to making our measure calculation code publicly available. Lastly, we're also responsive to stakeholder input, which is described in more detail on the next slide.

This slide shows the historical timeline of the star ratings program and stakeholder engagement efforts mentioned on the prior slide. While stakeholder input has been valuable over the full duration of the Overall Star Rating project, dating back to the Overall Star Rating dry run in 2015, followed by the program launch in 2016, this slide focuses specifically on the last five years. Here you can see that over the last five years, we've held a Technical Expert Panel in addition to several provider and Person & Family Engagement workgroups, and we've also held public comment periods. On the bottom portion of the visual, you can see several National Provider Calls, like this one that we've held over the past five years, in addition to the callout in light blue flagging the inclusion of VA hospitals in the star rating beginning in 2023. Over the last 10 years, the methodology has been updated four times, including most recently for this 2026 star rating release, so I'm going to hand it over to Cameron Gettel to introduce the changes for the 2026 Overall Star Rating.

**Dr. Cameron**

**Gettel:**

Thank you, Eve. Hi, everyone. My name is Cameron Gettel. I'm a project lead for the star ratings team.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Today, I'm going to talk about some of the changes for the Overall Star Rating and then go into some of the results that we've seen for 2026.

First, looking at the Overall Star Ratings, the changes for 2026, there are three main changes. This slide is meant to be a signpost. Then, in the following slides, I'm going to go over each in a little bit more detail. First, SAS statistical software was used in prior star rating methodologies and calculations. That has been transitioned to R instead. The second category of changes also reflects the underlying measures.

In the Mortality measure group, the Hybrid Hospital-Wide Mortality measure has been added, as well as five additional measures in the Patient Experience group. Separately, the Perinatal Care measure and the COVID-19 Vaccination Coverage measures have both been retired and are not present in the 2026 methodology. Finally, there's been a methodology update to emphasize the Safety of Care measure group. In short, hospitals in the lowest quartile of the Safety of Care measure group that at least have three measures reported are capped at a maximum of four star ratings. Separately, in the following year in 2027, Safety of Care will be emphasized a little bit more broadly by applying a one-star reduction across two, three, four, and five-star rating categories for hospitals that perform in the lowest quartile of Safety of Care measure group, again, that have at least three Safety of Care measures reported.

The first change I mentioned reflected the SAS to our transition, and this was a manifestation of CMS decommissioning its licenses for the SAS statistical software at the end of 2025. This is primarily a technical change. The Overall Star Rating is indeed easily accommodated in R, as it did not use specialized functions unique to SAS.

Testing of both SAS and R showed broadly consistent results between the two statistical software packages. Like the SAS pack, the R pack will again be publicly available.

The second change that I mentioned regarded the underlying measures.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

The most substantial change for 2026 is the addition of the OAS CAHPS measures, and that stands for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems measures. The Overall Star Ratings Patient Experience group previously included only measures based on the hospital inpatient CAHPS item level STAR Ratings. The addition of the OAS CAHPS measures, the outpatient, were introduced to Care Compare in October of 2025 and, therefore, meet STAR ratings inclusion criteria. With the addition of OAS CAHPS measures, the Patient Experience group will now use publicly reported linear mean scores for all measures.

Continuing with the Patient Experience group measures, you can see on the left the 2025 Patient Experience measure group, and, on the right, the 2026 Patient Experience group measures. The Cleanliness and the Quietness of the Hospital measure on the left in 2025 was split into individual measures in 2026. Separately, the Overall Rating of the hospital and the Willingness to Recommend the hospital was also split from 2025 to 2026 for individual measures. Additionally, in red, you can see the addition of the OAS CAHPS measures in the Patient Experience measure group in 2026.

The third methodologic update or change that I mentioned was the emphasis on Safety of Care. Recently, CMS has been increasing efforts to highlight and emphasize the patient's safety across programs and measures, including this Safety of Care group in Overall Star Ratings, the Hospital-Acquired Condition Reduction Program, or HAC RP, and new Patient Safety Structural Measure. The intent of this change is to address the concern that hospitals could receive the highest possible five-star rating despite performing poorly in the lowest quartile of the Safety of Care measure group. Safety of Care is one of the five measure groups integral to the Overall Star Rating. This change has been finalized in the 2026 outpatient final rule, where a four-star cap will be applied for hospitals in the lowest quartile of Safety of Care measure group performance, again, assuming they had at least three Safety of Care measures.

This slide may be familiar to prior attendees of National Provider Calls.

## Hospital Inpatient Quality Reporting (IQR) Program

---

### Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

We made slight adjustments given the recent changes to the Safety of Care measure group. On this slide, we'll briefly walk you through each of the now nine steps that comprise the star ratings methodology. On the left is Step 1. That's the first step, and that's the selection of measures. In the 2026 star ratings, there are 52 measures that will comprise the star ratings. Those measures are selected from the stakeholder input, from prioritization, and ensuring that at least 100 hospitals report on Care Compare and are scored on each of those measures. Each hospital is scored on that measure, and their scores are ultimately standardized. For some measures, a higher score may be better, and, for other measures, a lower score may be better. So, in Step 2, we ensure standardization before we move forward with other steps. The 52 measures are grouped into five groups that you see in purple for Step 3: Mortality, Safety of Care, and Readmission groups comprise our outcome measure groups, and Patient Experience and Timely & Effective Care comprise the process measure group. For example, Safety of Care has eight measures that comprise the group. In Step 4, we then calculate a group score. For example, if a hospital has all eight Safety of Care measures reported and scored on, then the group score for Safety of Care is simply the average of those eight individual standardized measure scores.

In Step 5, we then generate a summary score. A hospital summary score is the policy-based weighted average of those available hospital group scores. Again, for example, the Timely & Effective Care group contributes 12% weight to that summary score, and the other four groups each contribute 22% to comprise the full 100% hospital summary score. If, for example, a hospital has no measures within the Safety group score, then the other group scores are proportionally up weighted to result in the full 100% contributing to the hospital summary score. In Step 6, we then apply reporting thresholds. So, hospitals must report at least three measures in at least three groups to obtain a star rating. One of those groups, importantly, must be mortality or safety. In Step 7, we apply peer grouping. The goal of this step is to ensure that hospitals are compared to like hospitals.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

The hospital's peer group is determined by how many measure groups they have at least three measures reported on and scored. So, if a hospital has two measures in the Readmission group, the maximum peer group that they could be in is Peer Group 4, if they have at least three measures in all the other groups. As we'll see in the coming slides, the vast majority of hospitals within the 2026 star ratings are within Peer Group 5. In the eighth step, hospital summary scores are categorized into five clusters using a k-means clustering algorithm. In the newly added ninth step, five stars are assigned to the highest cluster and one star to the lowest cluster. Furthermore, a four-star cap is applied to the hospitals that score in the lowest quartile on their Safety of Care measure score and report at least three safety measures.

Now that we discussed the methodology and provided updates, we'll show the results of the 2026 Overall Star Ratings.

The number of hospitals that received a star rating in 2026 was considerably more than in prior years. In 2025, 2,891 hospitals received a star rating, and a net 312 more hospitals, for a total of 3,203, received a star rating in April of 2026. Thirty-eight hospitals no longer met criteria for a star rating, and 350 hospitals newly met criteria for a star rating.

This slide shows the Overall Star Ratings distribution between years, 2025 on the left in light blue and 2026 on the right in darker blue.

Approximately 31 to 33% of hospitals received three stars across the years. Approximately 37 to 42% received four or five stars across the years, and about 27 to 31% received one to two stars. So, there is rather similar distribution across the years.

This slide shows the number of hospitals with a star by peer group across the years. Peer Group 5 is the most common, as you can see, and more than 70% of hospitals fell into Peer Group 5 across the years. The difference this year with the 312 more hospitals receiving a star rating was seen in Peer Group 4, as 515 hospitals were in Peer Group 4 in 2025, compared to 749 in 2026, a considerable increase. The coming slides will show the reasons for that.

## Hospital Inpatient Quality Reporting (IQR) Program

### Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

This slide goes into a little bit more detail and now shows a stratification of star ratings by peer group and across years. The takeaway for this, if you can look at the 2025 Peer Group 5 and the 2026 Peer Group 5 columns, you can see relatively similar distributions across the years. If you compare Peer Group 3 across 2025 and 2026, you can see that Peer Group 3 hospitals had slightly higher tendency to receive one or two stars in 2026, 31% of Peer Group 3 hospitals compared to 21% of hospitals in 2025. Conversely, Peer Group 4 hospitals in 2026 had a greater tendency to receive 4 or 5 stars. You can see that by 31 plus 12, equaling 43% compared to 31% in 2025.

Now, we are getting into some of the reasons for these changes. At the measure group level, we see that there was considerable increased reporting in the Mortality and Patient Experience measure groups. This goes with the increase in measures being reported in both those groups that I mentioned earlier. In Mortality, we saw well over 4,000 hospitals reporting at least one measure in the Mortality group, an increase of more than 400 from the year prior. In Patient Experience, we saw well over 3,000 hospitals reporting at least one measure in the group. Again, that is an increase of over 300 hospitals from the year prior.

Within the Mortality group, the measure newly added that I had mentioned earlier was a Hybrid Hospital-Wide Mortality measure. To orient you on some analyses at the bottom of the slide, on the left in gray is a world in which Hybrid Hospital-Wide Mortality was not included in the Mortality group. The blue is if Hybrid Hospital-Wide Mortality was included, as is the current state in 2026, and 89 hospitals would not have received a star rating without the Hybrid Hospital-Wide Mortality measure. These 89 became part of Peer Group 3 as a result of that measure being reported and being scored. You can also see that 257 hospitals moved from Peer Group 3 to Peer Group 4, and 58 hospitals moved from Peer Group 4 to Peer Group 5. In all these cases, the Hybrid Hospital-Wide Mortality measure became the third mortality measure needed to generate a new star rating or to move up a peer group for these hospitals.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Therefore, this was the isolated impact of the addition of this Hybrid Hospital-Wide Mortality measure.

The same orientation stands for this slide looking uniquely at the impact of the OAS CAHPS measure addition. Four hospitals, as a result of the addition of OAS CAHPS, would have went from unrated to Peer Group 3, and 98 hospitals moved from Peer Group 3 to Peer Group 4, and 16 hospitals moved from Peer Group 4 to Peer Group 5 in a world where OAS CAHPS was not present to the current state where OAS CAHPS present measures are in 2026.

The final change that I had mentioned earlier was the Safety of Care cap. Just to reiterate, CMS intended to emphasize the importance of the Safety of Care measure group, particularly to address the issue where hospitals could receive five stars despite performing in the lowest quartile of Safety of Care measure group performance. In 2026, this was the vast minority of hospitals. A total of 15 or well less than 1% of all hospitals were capped at four stars. If you'd like to see more information regarding the Safety of Care cap, you can find that in the 2026 OPSS and ASC final rule, published in November of 2025.

Finally, I have two slides here to show the differences between 2025 and 2026. The first slide shows the differences in peer grouping between the years. Just to orient you on the table, on the left is the 2025 stars Peer Group, 3, 4, and 5. On the top line is the 2026 stars Peer Group, 3, 4, and 5. If a hospital had the same peer group year to year, you can see that on the diagonal purple. That was the vast majority of hospitals that received a star rating in both years, and 92% had the same peer group. A small minority went from a lower peer group to a higher peer group, shown in the light blue, light purple. Similarly, a smaller number in pink went to a lower peer group. The noteworthy difference that I mentioned earlier was that 350 hospitals newly received a star, and you can see that in bright yellow. The 38 that no longer received a star are in orange on the right.

This reclassification table separately looks at the shift now in star ratings.

## Hospital Inpatient Quality Reporting (IQR) Program

---

### Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

On the left is the 2025 star rating for a hospital, and on the right, on the top, is the 2026 star ratings for the hospital. Again, if the hospital had the same star rating between the years, that would be captured in the diagonal purple. About 53% of hospitals had the same star rating year to year. About 29% increased by one or more stars, again, depicted by the light blue, light purple, and about 18% decreased by one or more stars, depicted in pink. Again, you can see the same 350 hospitals that newly entered stars and the 38 that no longer received a star in yellow and orange, respectively.

In summary, a net of 312 more hospitals received a star rating. This reversed a trend over the last few years where fewer hospitals were reporting sufficient measure information to be eligible for a star rating. The underlying reasons for that are likely the incorporation of the Mortality and Patient Experience measures. Of note, Peer Group 4 had the largest increase in the number of hospitals included. I will now turn the presentation over to my colleague, Kyle Bagshaw.

**Kyle Bagshaw:**

Thank you, Dr. Gettle. Hello, everyone. My name is Kyle Bagshaw. I'm a co-lead of the Star Ratings Project at Yale/CORE. At this point, I'd like to address a few frequently asked questions that hospitals often ask about the Overall Star Rating methodology and refreshes.

The first question I'll be answering is: Why aren't those Overall Star Ratings released in the same quarterly refresh each year?

CMS has selected refresh criteria within the bounds of rulemaking once every year using data from within the previous 12 months in order to maximize the available information consistent with the guiding principles. For the 2026 star rating, we selected a data period that maximizes the number of hospitals eligible to receive a rating and accommodates several individual measure updates and recalculations, particularly the addition of the newly reported OAS CAHPS measures that were introduced in October 2025.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Our second question here is: Why is the Overall Star Rating peer group based on the number of measure groups rather than any other hospital characteristics?

Peer grouping was introduced to the Overall Star Ratings methodology in 2021 with the goal of making like-to-like comparisons among hospitals in the program. As Dr. Gettle mentioned before, these peer groups are defined by the number of measure groups for which hospitals report at least three measures. These peer groups correspond to hospital differences, like size, volume, and case and service mixes that align with other characteristics of interest. The number of hospitals by peer groups is 177 or about 6% operated hospitals in the three-measure group peer group, also known as Peer Group 3; 749 or 23% are in Peer Group 4; and the majority of rated hospitals, 2, 277 or 71%, are in Peer Group 5.

There are several trends that we can notice that correspond to hospital peer group assignments, specifically regarding the measure groups involved. Compared to Peer Group 5, we see that many fewer hospitals in Peer Group 4 have at least three Safety of Care measures, making the Safety of Care measure group the key factor distinguishing Peer Group 5 from Peer Group 4. Similarly, compared to Peer Group 4, many fewer hospitals in Peer Group 3 have at least three Patient Experience measures, making the Patient Experience group the key factor differentiating those peer groups. A majority of hospitals in all peer groups have at least three measures in each of the Mortality, Readmission, and Timely & Effective Care measure groups.

As I previously noted, the peer group assignments also correspond with other hospital characteristics of interest. Particularly we see that hospitals in Peer Group 5, highlighted in this red column, are more likely to be non-critical access, non-safety net, teaching hospitals, urban hospitals, and/or larger facilities compared to those in Peer Groups 3 and 4. So this is highlighted in the red column to the right under Peer Group 5. Again, over 99% of these hospitals are non-critical access, and well over half are non-safety net, urban, and larger hospitals.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Our third question is: Do hospitals influence the Overall Star Rating by choosing which measures to report?

Hospitals participating in CMS programs are required to collect data for measures reported on Care Compare on Medicare.gov. Each underlying measure has established thresholds, such as a minimum case count, for a hospital's score to be publicly reported in order to ensure reliable measurement. If a hospital does not meet the threshold for a given measure, its score is not reported publicly, and its performance on that measure does not factor into its Overall Star Rating. However, in general, hospitals do not have a choice in measures for which their data is collected and reported and do not have a choice in which measures are factored into the star rating.

Our fourth question is: Why did my hospital's Overall Star Rating change since last year?

While many hospitals got the same Overall Star Rating in 2026 as 2025, approximately half received a different rating than they had last year. The Overall Star Rating can change when a hospital performance on underlying measures shifts relative to its peer hospitals. Some ways in which this can happen is if the hospital itself performs better or worse than the prior year. The hospital may have performed similarly, but its peers collectively have performed better or worse. We also note that shifts in groups or measures that have greater weight towards hospital summary scores would be more likely to result in star rating shifts.

We also note that hospitals which are initially closer to the cutoff points between star rating categories may be more susceptible to shift. Finally, hospitals changing to a different peer group assignment can lead to shifts due to the comparison to a different group of peers than in prior years.

Regarding peer group shifts, again, most hospitals, over 90%, are in the same peer group as they had been in 2025, but some move to a higher or lower peer group.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Hospitals can shift peer group based on the reporting of individual measures. Hospitals may shift based on reporting of individual measures based on meeting or not meeting measure level requirements such as case counts or minimum samples. For the example here, we have a hypothetical hospital that had three or more measures in all groups except Mortality in 2025. In 2026, this hospital now met the criteria for a third Mortality measure. As a result, the hospital moved from Peer Group 4 to Peer Group 5. We note that this is consistent with the guiding principle of the Overall Star Rating to be flexible as the universe of hospitals and quality information evolves.

Our final frequently asked question is: How do I know if my hospital was impacted by the four-star cap that emphasizes Safety of Care?

CMS does not plan to specify on Care Compare preview reports or Hospital-Specific Reports when a hospital has been impacted by the four-star cap. However, a hospital can identify this by comparing their hospital summary score that is reported in the Hospital-Specific Report to the ranges for each K-means cluster that are included in the Overall Star Rating methodology report published on QualityNet. If a hospital's summary score falls within the five-star range for their peer group, but the hospital had instead received a four-star rating, then that hospital had been impacted by the four-star cap.

Thank you. I will now hand it over to Ms. Dawn Beard to discuss the implementation of the 2026 Overall Star Rating.

**Dawn Beard:**

Thank you, Kyle. Today, I'll be highlighting the implementation dates for the 2026 Overall Star Ratings publication. CMS intends to have the April 2026 Overall Star Rating Measure Detail Hospital-Specific Report, also known as the HSR, available on February 19. The HSRs provide details on the star rating calculations and the October 2025 data that was used for the calculations. The HSRs can be accessed directly from the Hospital Quality Reporting System. For April 2026, the Measure Detail HSR will be available to download in either a PDF format or a CSV format.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

The PDF version provides rounded values, whereas the CSV version provides the full values used for the calculations. We highly encourage you to review the HSR User Guide for more information. This user guide can be found on QualityNet, but it also will be coming in with the bundle when you download your HSRs. The preview period for April 2026 is scheduled for February 19 through midnight on March 20. As a reminder, the intention of the preview period is for providers to review their star ratings data prior to them being publicly reported on Care Compare on Medicare.gov. The preview period is not a review and correction period where providers can send corrected data as the data included in the calculations was already publicly reported in October 2025. CMS intends to publish the April 2026 Overall Star Ratings on May 13. Please note release dates are subject to change at CMS discretion.

This slide provides links for the Overall Star Rating resources providers can use. CMS provides resources such as data collection periods; the comprehensive methodology, which is now Version 5.0; the user guide; and frequently asked questions. These documents will be found on QualityNet star rating web pages once preview begins and not before. Questions concerning the Overall Star Ratings can be submitted to the team by using the [QualityNet Question and Answer Tool](#). Under the Program drop-down, please select Overall Hospital Star Ratings. Then, choose your specific topic. This will ensure that your questions are sent directly to our star rating team. Thank you for attending today's presentation, and I will turn it back over to Donna.

**Donna Bullock:** Thank you, Dawn. We do now have some time for some questions and answers. If we do not get to your question during the webinar, you can send your inquiry to the Overall Star Ratings team using the link Dawn provided on slide 46. So, let's get to our first question. Okay, here's our first question. How are the peer groups determined?

**Cameron Gettel:** I can take that one. Thank you. Just as a refresher for all attendees, CMS categorizes hospitals into peer groups by number of measure groups for which they have at least three measures with adequate reported measure data.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

The goal of peer grouping is really to allow like-to-like comparisons with characteristics of hospitals within a peer group sharing broadly similar size, volume. Hospitals are categorized into one of three peer groups. So, a three-measure group peer group would be Peer Group 3. Then, there's Peer Group 4 and Peer Group 5, which was the most common if they have at least three measures in all five groups. So, I hope that answers that question. Thank you.

**Donna Bullock:** Thanks, Cameron. Our next question is: How can you verify your hospital's peer group?

**Cameron Gettel:** That's another good question. A hospital can identify its peer group within its Hospital-Specific Report, or HSR. You may have heard it called that. However, peer groupings are not publicly reported, and there are not resources available to know what other hospitals are included in each peer group. So, a hospital's peer group categorization will not be publicly reported via the [Compare tool on Medicare.gov](#) or in any data set. That was based on prior stakeholder input, particularly from our Person & Family Engagement workgroup, and CMS decided not to publicly report peer grouping categorization as it really could cause further confusion for patients compared to the star ratings that could be reported as well.

**Donna Bullock:** Thank you, Cameron. Our next question is: Where can we find the minimum case counts and denominator thresholds by measure?

**Kyle Bagshaw:** Hi, this is Kyle Bagshaw from CORE. I can respond to this one. Thank you. So, we just want to note that the case minimums for each measure are not set by the Overall Star Rating. CMS uses the quality measure scores that are publicly reported on Care Compare on Medicare.gov. So, the help guides for the inpatient and outpatient programs available on QualityNet will list the minimum counts for each measure, including those that are in the star ratings. I just want to note these documents are updated, updated quarterly and available to assist hospitals.

## Hospital Inpatient Quality Reporting (IQR) Program

### Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

**Donna Bullock:** OK. Here's our next question: If hospitals do not meet the Hospital IQR Program reporting requirements, would they be excluded from the star rating, or could their data still be used?

**Kyle Bagshaw:** All right. This is Kyle from CORE, and I can respond to this one as well. So, the Overall Star Rating uses, again, the measure data results that are publicly reported. So, as noted before, measures need to meet those minimum reporting requirements to be able to be included, but if a hospital does meet the criteria for its measure scores to be publicly reported, then that data will be used in the star rating calculation. So, again, that's any hospital that has a score for a measure, that score can factor into the standardization process of the measure scores. That's determined before the ratings are assigned. So, again, to be assigned a rating a hospital must have a minimum number of at least three measures and at least three measure groups. One of which must be Mortality or safety, but any individual measures that a hospital reports will be included regardless of the hospital qualifying for the star rating.

**Donna Bullock:** OK. Thank you, Kyle. Here's our next question: Why is Safety of Care being emphasized as opposed to other measures? Won't this minimize the influence of the other measure groups?

**Cameron Gettel:** Cameron here again. I can address that one. Even hospitals in the lowest quartile of Safety of Care can still achieve ratings as high as four stars in this proposal based on strong performance in the other measure groups. While the proposed update increases the emphasis on Safety of Care relative to other measure groups, it does not drastically alter the overall approach. Furthermore, federal efforts, such as the National Action Alliance to Advance Patient and Workforce Safety and recommendations from the President's Council of Advisors on Science and Technology, are also reinforcing patient safety as a national priority, and this is aligned with CMS's initiatives like the National Quality Strategy and the Universal Foundation. So, the proposed methodology, the proposed updates within the methodology better align with the Overall Hospital Quality Star Ratings with other CMS efforts.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

**Donna Bullock:** All right, thank you, Cameron. Here's our next question. Why aren't other measures of patient safety included in the star ratings?

**Kyle Bagshaw:** This is Kyle Bagshaw from Yale. So, the current Safety of Care group as it's composed includes all of the currently reported measures that meet the inclusion and exclusion criteria established in the star rating methodology. So, those are the six hospital-associated infection measures as well as the kidney complication measure and the PSI-90 measure. So, we want to note that as the universe of publicly reported measures evolves and new measures that also meet the criteria are publicly reported, CMS will be incorporating these measures into the star rating as well.

**Donna Bullock:** Thank you, Kyle. Will CMS provide technical support for the use of the R pack?

**Kyle Bagshaw:** This is Kyle again from Yale. Unfortunately, CMS cannot provide direct technical support to users of the R pack. We do make supporting documents available to facilitate use that are available for download from the QualityNet website. We do believe that the open-source nature of the R software package will facilitate more use of these tools by hospitals and researchers and other users and improve the accessibility of this. Again, this is not an area that CMS can provide direct user support.

**Donna Bullock:** Thanks, Kyle. Why is a quartile-based approach used for categorizing Safety of Care performance?

**Cameron Gettel:** This is Cameron here from Yale/CORE. I can take that one. Using a quartile-based approach for the four-star cap, we acknowledge could sometimes result in hospitals receiving a lower Overall Hospital Quality Star Rating, even if their overall performance actually improved. The foundational principle of "Do No Harm" is prioritized by CMS in their rationale for making this methodology update to the Safety of Care measure group. The quartile approach to define poor performance emphasizes patient safety more globally. So, all hospitals should be working to produce safer outcomes and minimize adverse events in their facilities.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Additionally, we've retired "topped out" measures on which most hospitals have come to perform highly, in which case such measures would no longer be eligible for the Overall Hospital Quality Star Rating. Currently, no Safety of Care measures approach topped out status, indicating there is continued room for improvement as desired. We believe the quartile-based approach in conjunction with the requirement of at least three Safety of Care measures provide a subtle balance emphasizing Safety of Care broadly across all hospitals, and not just a few extremely low performers. It also ensures that only hospitals with performance demonstrably lagging national trends would be subject to the four-star cap.

**Donna Bullock:** Thank you. Here's our next question, two questions: Will a hospital be able to see or predict its quartile of performance in the Safety of Care measure group? Will CMS publicly report hospitals that have performed in the lowest quartile?

**Cameron Gettel:** Thank you, Donna. I can take that one too. It is a good question. We've heard sentiments several times. So, while a hospital can see its Safety of Care measure group score in its HSR, in its Hospital-Specific Report, it can roughly infer its performance compared to others, but CMS does not explicitly report the quartile ranges for Safety of Care or any other measure group. CMS will not publicly report a hospital status regarding the Safety of Care four-star cap on Care Compare, on Medicare.gov, or anywhere publicly reported.

A hospital's relative performance in the Safety of Care measure group can be assessed at a high level by reviewing the standardized measure group score in the hospital's HSR, though its precise performance quartile cannot be directly calculated. If desired to compare more specifically, Safety of Care quartile performance can actually be directly calculated using the publicly posted SAS or R pack and input file found on QualityNet, as those will provide full distribution of safety measure group scores across hospitals. So, users can then use these results to divide that data into quartiles and analyze it directly.

**Donna Bullock:** OK. Thank you. We have time for just a few more questions.

## **Hospital Inpatient Quality Reporting (IQR) Program**

---

### **Inpatient and Outpatient Healthcare Quality Systems Development and Program Support**

Here is our next question: How will a hospital know if they were subject to the four-star cap, the lowest quartile of Safety of Care measure group performance and reporting at least three Safety of Care measures.

**Cameron Gettel:** This is Cameron here from CORE. I can address that one. So, once a hospital's HSR is released, the hospital will be able to compare their hospital summary score noted in HSR to the hospital summary score ranges for each Overall Star Rating category provided in the methodology report. If a hospital has been impacted by the four-star cap, they would have received a four-star rating despite their summary score falling in the five-star summary score range for their individual peer group.

**Donna Bullock:** All right, and I think this is our last question. Which peer group do the majority of critical access hospitals fall into?

**Kyle Bagshaw:** Hi, this is Kyle Bakshoff from Yale/CORE again. I believe this can be seen from the data on slide 36 as well. Most critical access hospitals don't have sufficient measure information to meet the star rating criteria. Those that do, most are in Peer Groups 3 and 4. So, again, you can see that on slide 36 that 63% of the hospitals in Peer Group 3 are critical access; 39% of those in Peer Group 4 are critical access and less than half a percent of those in Peer Group 5.

**Donna Bullock:** Thank you. That is all the time we have for questions today. Next slide, please.

This program has been approved for one continuing education credit. If you registered for today's event, an email with the link to the survey and continuing education information will be sent to you within two business days. If you did not register for the event, please obtain this email from someone who did register. For more information about our continuing education processes, you can click the link on this slide.

That concludes today's presentation.

Thank you for joining us and enjoy the rest of your day.