Overall Hospital Quality Star Rating July 2024 Refresh Question and Answer Summary Document

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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.

The following document provides actual questions from audience participants. Webinar attendees submitted the questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Current Methodology

Question 1:	**Under Step 1 ("Select Measures") on slide 12, for the current Overall Star Ratings methodology, what is Measure 1, Measure 2, Measure 45, and Measure 46?**

Step 1 of the Overall Hospital Quality Star Rating methodology is the selection and standardization of measures for inclusion in the Overall Star Rating. The flow chart on slide 12 illustrates that 46 individual measures met the inclusion criteria for the Overall Star Rating for the 2024 refresh but was condensed for readability. The specific measures included are listed in Appendix C of the July 2024 Quarterly Updates and Specifications Report posted on QualityNet.

Question 2:	**Will CMS use standard time periods from now on (like year-to-year) versus 2 years, or 2.5 years, etc.?**

The Overall Star Rating only uses measure data that are publicly reported via the Compare tool on Medicare.gov and does not set the reporting periods for individual measures. CMS sets the reporting periods for each measure through its quality reporting programs.

However, some of the measures did not include the full reporting period due to the COVID-19 Extraordinary Circumstance Exception (ECE) for Quarter (Q)1 2020 and Q2 2020, and this prevented measures from using any data for any purposes collected during this time period. In the years when measure reporting periods start past those quarters, CMS will use the full reporting periods for all measures.

Peer Groupings

Question 3:	**How are the peer groups determined?**

CMS categorizes hospitals into peer groups by the number of measure groups for which they have at least three measures with adequate reported measure data. The goal of peer grouping is to allow like-to-like comparisons, with characteristics of hospitals within a peer group having

similar size, volume, and case mix. After the minimum reporting thresholds are applied, hospitals are categorized into one of three peer groups: a three-measure group peer group, a four-measure group peer group, and a five-measure group peer group.

Question 4: **How can you verify your hospital's peer group?**

A hospital can identify its peer group within its Hospital-Specific Reports (HSRs). However, peer groupings are not publicly reported, and there are no resources available to know what other hospitals are included in each peer group. A hospital's peer group categorization will not be publicly reported via the Compare tool on Medicare.gov or in any dataset.

Based on prior stakeholder input, particularly from our Person & Family Engagement Workgroup, CMS decided not to publicly report peer grouping categorization as it may cause further confusion for patients.

Question 5: **Does the hospital's peer group impact the likelihood of receiving a higher score? For example, is it "harder" to achieve a five-star rating for a peer grouping of five hospitals versus a peer grouping of just three hospitals?**

Star Ratings are assigned based on a k-means clustering of overall summary scores among hospitals within each peer group. This is an empirical method developed with significant stakeholder input, to ensure that hospitals of a given star rating within a peer group are closer to the average within their own star rating category than to the average of any other.

Because k-means clustering is applied in each peer group separately, the cut points between Star Rating categories can vary by peer group, and the distribution of star ratings may be different. However, this only depends upon the distribution of data within a given peer group for each year, and achieving a given star rating is not categorically dependent upon peer group.

Slide 20 shows the distribution of Star Ratings by peer group for both 2023 and 2024. The distribution of Star Ratings is similar between peer groups and years, but there are some fluctuations. For example, the percentage of five-star Peer Group 3 hospitals increased from 11.3 percent in 2023 to 14.8 percent in 2024, while the percentage of five-star Peer Group 5 hospitals decreased from 15.1 percent to 12.7 precent. (That is, Peer Group 3 hospitals were somewhat less likely to have five stars than Peer Group 5 hospitals in 2023 but somewhat more likely in 2024.)

Question 6:   **If reporting data in the Mortality domain is one requirement for Star Ratings, why is the proportion of hospitals in the three- and four-measure peer groups reporting Mortality domain data in 2023 and 2024 less than 100 percent (as shown in slide 32)?**

A hospital must receive at least three publicly reported measure scores in each of at least three measure groups, one of which must be Mortality **or** Safety of Care, to meet the Star Ratings minimum threshold requirement for receiving an Overall Star Rating. For example, if a hospital reported more than three measures in each of the Safety of Care, Readmission, and Patient Experience measure groups and two measures each in the Mortality and Timely and Effective Care measure groups, then it would still meet the threshold to receive an Overall Star Rating. In other words, a Peer Group 3 or 4 hospital may have fewer than three measures in either Safety of Care **or** Mortality, but it cannot have fewer than three measures in *both* those groups.

Question 7:   **Will CMS consider Star Ratings for smaller hospitals that don't meet the three peer groupings due to volume or services offered?**

CMS will take this into consideration for the future, but there are no plans for this at present. CMS continues to engage with a variety of providers, including leaders in delivery organizations (such as chief quality officers and chief medical officers) and hospital representatives, through our Technical Expert Panel (TEP), Provider Leadership Workgroup (PLWG), and CMS Listening Sessions to discuss future updates.

Question 8:   **Are there any plans for a Star Rating specific to critical access hospitals (CAHs)? The current methodology of peer-grouping based on number of measures reported doesn't feel like an accurate grouping of peers for CAHs that have a robust quality improvement program.**

CMS will take this into consideration for the future, but CMS has not proposed changes to the peer grouping methodology. CMS continues to engage with a variety of stakeholders, including leaders in delivery organizations (such as chief quality officers and chief medical officers) and hospital representatives, through our TEP, PLWG, and CMS Listening Sessions to discuss future updates.

CMS solicited feedback from the TEPs, public comments, and workgroups around various options for peer groups for CAHs. Following feedback from a variety of different stakeholders, CMS implemented the current peer grouping methodology based on measuring information.

To some extent, grouping by available measure information corresponds with other hospital characteristics. For example, most CAHs that meet criteria to receive Star Ratings fall within the three- or four-measure group peer groups, while very few are compared with Peer Group 5 hospitals.

The peer grouping method also preserves the intent and the principle around star ratings to ensure accessibility and simplicity of information, with a single summary rating of publicly reported quality measures to help consumers make informed health care decisions.

Question 9:   **Which peer group does the majority of the CAHs fall into?**

Most CAHs do not have sufficient measure information to receive a Star Rating. Of those that do in 2024 (n=164), most are in Peer Group 3 (33) and 4 (122), while only nine are in Peer Group 5. Thus, CAHs account for 29 percent of hospitals in Peer Group 3, 26 percent in Peer Group 4, and less than 0.5 percent in Peer Group 5. These data can be found on slide 33.

Extraordinary Circumstance Exceptions

Question 10:   **What does "ECE" mean? Is there a limit on the number of ECEs you can submit?**

An "ECE" is an Extraordinary Circumstance Exception. CMS understands that circumstances out of a facility's control may prevent a facility from meeting program reporting requirements. We offer a process for facilities to request an exception from certain quality reporting and value-based purchasing program requirements due to extraordinary circumstances beyond a facility's control. Such circumstances may include, but are not limited to, natural disasters (such as a hurricane or flood) or systemic problems with CMS data collection systems that directly affect a facility's ability to submit data. There is no limit as to the number of ECEs a facility can request. Each ECE request is reviewed, and a decision made on an individual basis. Additional information about the ECE Policy can be found on QualityNet.

Question 11:   **For the Measure Data Availability slides, were the various measure reporting periods adjusted to account for the excluded data of the COVID-19 ECEs, or were the reporting periods simply shortened for the COVID-19 ECEs?**

For the 2024 Overall Star Rating, data from within the COVID-19 ECE period was removed from measure score calculation, and the measure score was then calculated based on the remaining data. For example, measures that use or include 12 quarters of data now just include data from 10 quarters.

Star Ratings Distribution

Question 12:	**Is there a common reason why there is a decrease in chronic obstructive pulmonary disease (COPD) and heart failure (HF) mortality rates?**

To clarify the discussion on slide 22, we observed that the hospitals which qualified for Star Ratings in 2023 but not in 2024 were less likely to *report* (that is, to achieve sufficient case volume for public reporting) COPD and/or HF mortality in 2024, but this is not necessarily tied to changes in the actual mortality *rates* at these or other hospitals.

Of note, the hospitals in question mostly had only three mortality measures in 2023; likely, these are smaller hospitals that, because of case mix factors, were able to receive scores for just those measures. If volume at these hospitals dipped for any reason, they may no longer meet the necessary volume, losing their measure scores and in turn falling below the three measures in Mortality for the measure group to contribute to their eligibility for Star Rating.

Question 13:	**When you say most hospitals were excluded for mortality data, does that mean they did not have enough volume for the minimum number of mortality measures to qualify for that domain? If it is based on claims, it is not really possible for hospitals to not provide information.**

For mortality measures, measures do not meet public reporting minimums if the hospital has less than 25 eligible cases for the measure. Therefore, if a hospital does not meet this minimum threshold for at least three mortality measures, and the hospital does not meet minimum reporting requirements for at least three Safety measures either, then they do not meet the criteria to be eligible to receive an Overall Star Rating.

Question 14:	**Has there been any changes to the denominator process? We did not meet criteria for a 2022 star rating. We understand the core measures were not met for the Mortality and Safety of Care domains, but we cannot find the reason of decreased numbers. We haven't changed our process.**

There has not been any changes to the denominator process; however, the Overall Star Rating does not set the parameters for the measure-level calculations. The Overall Star Rating only uses the measure results that are publicly reported.

The Inpatient Public Reporting Preview Help Guide and the Outpatient Public Reporting Preview Help Guide list the minimum counts and other information on the measures. The documents are updated quarterly to assist hospitals in accessing and interpreting their preview data.

Question 15:   **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?**

Overall Star Ratings uses measure data results that are publicly reported on the Compare tool on Medicare.gov, and functions independently of successful compliance with the Hospital IQR Program requirements. Measures need to meet the public reporting minimum requirements. If measures results are publicly reported, the data can be used in the Star Rating calculations.

To be assigned to a star rating, hospitals must meet a minimum number of measures and measure groups. CMS requires at least three measures, in at least three measure groups, one of which must specifically be Mortality or Safety of Care. Any additional measures reported in any of the other measure groups are then included in the star rating calculation.

Question 16:   **Do the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) surveys play a part in the star ratings? Specifically, will low numbers of surveys result in not having a star rating? Was there no impact to the star ratings related to patient satisfaction?**

The Overall Hospital Quality Star Rating Patient Experience measure group is comprised of the HCAHPS components. Hospitals must report a required minimum of 100 completed surveys for linear scores to be calculated and provided, thus no HCAHPS data will be included in the star ratings if a hospital has less than 100 surveys. The Patient Experience Measure Group accounts for 22 percent of the total measure group weight. The breakdown of weights follows: Mortality, 22 percent; Safety of Care, 22 percent; Readmission, 22 percent; Patient Experience, 22 percent; and Timely and Effective Care, 12 percent. CMS calculates a

weighted average to combine the measure group scores into a single hospital summary score.

Question 17: **For those hospitals that dropped out of the Star Ratings, how many of them were CAHs?**

In 2024, 164 CAHs received a Star Rating (which may be inferred from slide 32). In 2023, 250 CAHs received a Star Rating, a net decrease of 86 CAHs.

Star Ratings Measure Information

Question 18: **Where can we find the minimum case counts and denominator thresholds by measure?**

Case minimums for each measure reported are not set by Overall Star Ratings at a measure level as CMS uses hospital quality measure scores that are publicly reported on the Compare tool on Medicare.gov for hospitals.

The Help Guides for Inpatient and Outpatient programs on QualityNet will list the minimum counts for measures. The documents are updated quarterly and made available to assist hospitals in accessing and interpreting their preview data. Help guides can be found on QualityNet.

[Inpatient Public Reporting Preview Help Guide](#)

[Outpatient Public Reporting Preview Help Guide](#)

Question 19: **What is the minimum number of cases to be able to report infections such as catheter-associated urinary tract infections or central line associated blood stream infection? Where can I find that information?**

On your Preview Report, your hospital's predicted number of infections is the predicted number of infections in scope for quality reporting. The predicted number of infections is calculated using national aggregate NHSN data from 2015 (resulting in the updated Standardized Infection Ratio [SIR] baseline described above) and is risk adjusted for your hospital based on several factors. The predicted number of infections is used by NHSN as the denominator to calculate your hospital's SIR.

Your hospital's reported number of infections is the observed number of infections reported by your hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate your hospital's SIR.

The SIR is a summary measure used to track HAIs at a facility, state, or national level over time. The SIR is calculated as observed number of infections (numerator) divided by the predicted number of infections (denominator). The number of predicted infections is adjusted based on several factors specific to your hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

When a hospital's SIR cannot be calculated for a HAI measure because there is less than one predicted infection, or because the hospital's C. difficile prevalence rate is above the allowed threshold, the SIR displays "N/A (with Footnote 13)" to indicate the results could not be calculated.

Please send your specific questions on HAI measure calculations to the NHSN team at nhsn@cdc.gov. Further information can be found in the Inpatient Public Reporting Preview Help Guide on QualityNet. The documents are updated quarterly and made available to assist hospitals in accessing and interpreting their preview data.

Question 20: **Where can we find the summary score range for each star rating?**

The July 2024 range of summary scores for each star category within each peer group can be found in the July 2024 Quality Updates and Specification Report, Table 6, posted on QualityNet.

Question 21: **In 2023, there were 47 measures; however, for 2024, it shows only 46 measures. What measure was removed?**

The 2023 Star Rating included the same 46 measures as in 2024. The list of measure inclusions and exclusions may be found in the Quality Updates and Specifications Report issued each year.

Question 22: **Are there any new measures being added to any of the measure groups for this year's star ratings, or are any measures removed/retired from any of the measure groups?**

The July 2024 Overall Hospital Quality Star Rating was calculated using measure data from the January 2024 Compare tool on Medicare.gov refresh.

CMS considers measures publicly reported on the Compare tool on Medicare.gov for inclusion in the Overall Hospital Quality Star Rating prior to each Star Rating refresh. If CMS finalizes a measure for removal from one program (e.g., Hospital IQR Program) but keeps the measure in another program (e.g., Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, or Hospital Readmissions Reduction Program), CMS will consider it for inclusion in the Overall Star Rating.

For July 2024, CMS did not add or remove any measures from the July 2023 refresh.

HSRs and Releases

Question 23: **When will CMS release the Star Ratings? Will CMS release the cut points for star ratings in advance of the report release?**

The overall summary score cut points between Star Rating for each peer group are found in the [Quarterly Updates and Specification Report. This report](#) was posted on the QualityNet Star Ratings page when the HSRs became available on May 3, 2024. They will not be released prior to that.

Question 24: **Will the July 2024 Star Rating release be based on the January 2024 refresh?**

Yes, CMS used measure data from the January 2024 refresh, publicly reported on January 31, 2024, for the July 2024 Overall Star Rating calculations.

Question 25: **What was the release date of the data used for the Star Ratings?**

CMS used measure data from the January 2024 refresh, publicly reported on January 31, 2024, for the July 2024 Overall Star Rating calculations.

Question 26: **What particular components in our HSRs should we review to understand where our greatest opportunity to improve our Star Rating lies? What are the best strategies to improve our star ratings or best resources to review for that goal?**

Shifts in Star Ratings are expected. As measures are added, removed, or updated via the Compare tool on Medicare.gov, and as data periods for various measures are refreshed, a hospital's Overall Star Rating may change. Also, summary score ranges will change from release to release due to the underlying distribution of hospital data.

The Overall Star Rating is based on a hospital's performance compared to the hospitals in the nation. This comparison might account for changes in your hospital's Overall Star Rating if your hospital did not improve as much or more than the hospitals in the nation.

The Overall Star Rating summarizes quality across the five measure groups (Mortality, Safety of Care, Readmission, Patient Experience, Timely and Effective Care) using individual measure scores as observations. A hospital may improve its Overall Star Rating by improving performance on measure scores.

Measure group scores are calculated using a simple average of measure scores. In other words, every measure that a hospital reports will have equal contribution to the measure group score. A simple average of measure scores simplifies the methodology and allows stakeholders to better predict the emphasis of each measure, and in turn better anticipate changes in their star rating and focus quality improvement efforts.

A hospital may improve their star rating by improving performance on the individual measure scores weighted the highest for their hospital based on the number of measures reported within each measure group. The measure group weights follow: Mortality (22 percent), Safety of Care (22 percent), Readmission (22 percent), Patient Experience (22 percent), and Timely and Effective Care (12 percent). It is important to note that the Overall Star Rating methodology is comparative in nature, ultimately assigning hospitals to star ratings relative to other hospitals.

Question 27: **Why are the number better, number worse, and number same comparisons marked as N/A under my Timely and Effective Care group and HCAHPS measures?**

Patient Experience and Timely and Effective Care measures do not have publicly reported national-level measure results to allow for "above," "below," or "same as" the national average comparisons.
The measure performance category is based on your hospital's measure results compared to the publicly reported national-level measure results, and national-level results are not available. Therefore, N/A is shown for those measure group results.

<u>Resources</u>

Question 28:	**Is there a 30-day Mortality fact sheet to share with medical staff/coworkers? Are there other measure fact sheets as well?**

Resources related to all hospital quality measures reported by CMS may be found via the [QualityNet.cms.gov](https://qualitynet.cms.gov) website. For example, fact sheets and other resources for the 30-day mortality measures may be found here: https://qualitynet.cms.gov/inpatient/measures/mortality/resources

Question 29:	**We created a model using internal data to attempt to predict future star ratings. Are there any observations on national performance that we should incorporate into our model (like national improvement in acute myocardial infarction mortality, etc.)?**

The Overall Hospital Quality Star Rating is intended only as a snapshot of hospitals' performance relative to their peers at a single point in time, as a resource to help consumers understand quality information and make informed healthcare decisions. As such, future star ratings will depend on many factors in an evolving quality environment (not only for a hospital of interest, but among all of its peers as well), and the ability to predict future ratings will be very limited, even when incorporating internal data and overall national trends.