



PPS-Exempt Cancer Hospital Quality Reporting Program Public Reporting Preview Help Guide

**October 2021 Public Reporting Preview/
January 2022 Provider Data Catalog Release**

Hospitals participating in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program are the target audience for this publication.

The document scope is limited to instructions for hospitals to access and interpret the data provided on the public reporting user interface prior to the publication of data on Provider Data Catalog website.

CMS will not use data reflecting services provided January 1, 2020–June 30, 2020 (Q1 and Q2 2020) in its calculations for Medicare quality reporting.

CMS recognizes the ongoing impact of the COVID-19 Public Health Emergency (PHE) on the ability to submit quality measure data. As a result, CMS granted Extraordinary Circumstance Exceptions (ECEs) to individual hospitals that indicated the impact of the PHE continued beyond the already excluded Q1 2020 and Q2 2020 data submissions.

A new footnote will be applied to the measure data identified by those providers. See the Footnote section of this guide for more information.

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Overview

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of the United States Department of Health and Human Services (HHS) to establish procedures for making the data submitted under the PCHQR Program available to the public.

On September 3, 2020, CMS announced that new Compare tools were available on Medicare.gov. They are Care Compare (<https://www.medicare.gov/care-compare/>) and Provider Data Catalog ([PDC](https://data.cms.gov/provider-data/)) (<https://data.cms.gov/provider-data/>).

On December 1, 2020, CMS retired the *Hospital Compare* tool, the location of PCH data. The [PDC](https://data.cms.gov/provider-data/) site is the new location for PCH data. The [PDC](https://data.cms.gov/provider-data/) site can be accessed at <https://data.cms.gov/provider-data/>.

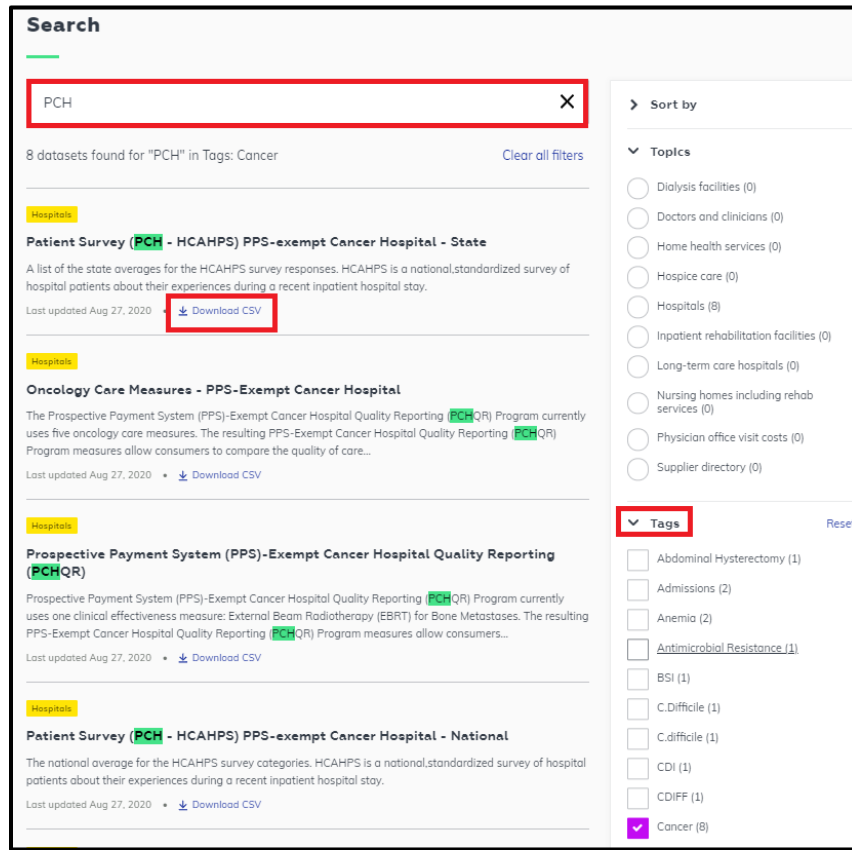
Provider Data Catalog (PDC)

Navigating the data catalog on data.cms.gov.

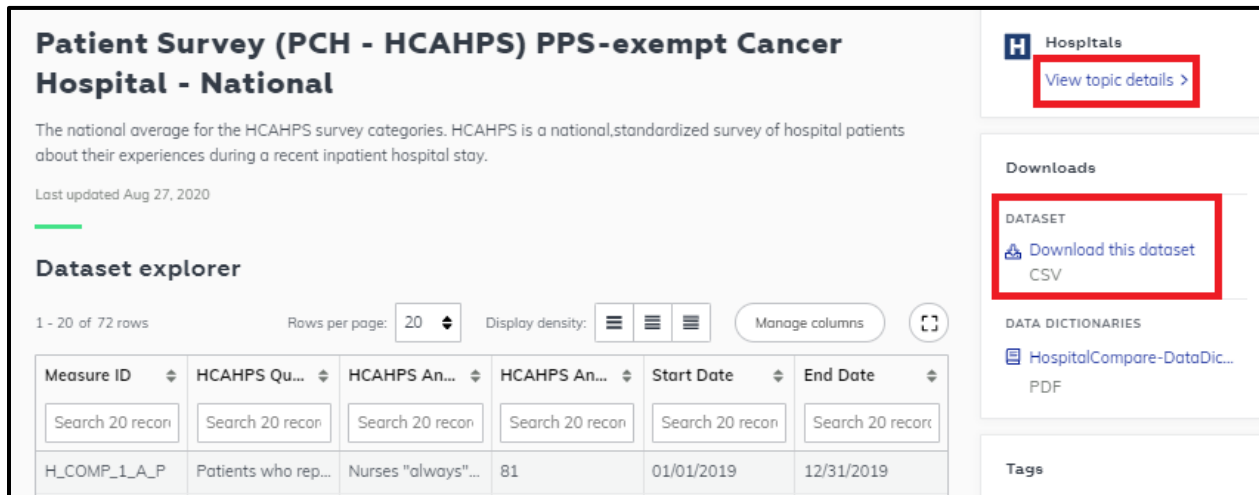
1. Select **Datasets** on the home page.



2. On the Landing page, users will be able to easily view data sets. This page is an interactive search window listing of all the data sets with sorting and filtering options.



- Users can easily download the dataset into a Comma-Separated Value (CSV) format. Users should select the dataset’s title for the specific dataset page. Users can view the publicly displayed data on the Dataset explorer.



- On the view topic details page, users are able to view and download achieved dataset data as well as gather additional information and background regarding the data.

PCHQR Program

The Social Security Amendments of 1983 exempted certain classified cancer hospitals from the Medicare inpatient prospective payment system (IPPS). These PCHs were also exempted from reporting on hospital inpatient quality measures. In 2010, the Affordable Care Act required CMS to establish a specialized quality reporting program for the PCHs. The resulting PCHQR Program measures allow consumers to compare the quality of care given at the 11 PCHs currently participating in the program.

Section 3005 of the Affordable Care Act added sections 1866(a)(1)(W) and (k) to the Act. Section 1866(k) of the Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act (referred to as “PPS-Exempt Cancer Hospitals” or “PCHs”) that specifically applies to PCHs that meet the requirements under 42 CFR 412.23(f). Section 1866(k)(1) of the Act states that, for fiscal year (FY) 2014 and each subsequent fiscal year, a PCH must submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such fiscal year.

For additional background information, including previously finalized measures and other policies for the PCHQR Program, please refer to the following final rules: FY 2013 IPPS/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Final Rule (77 Federal Register [FR] 53555–53567); FY 2014 IPPS/LTCH PPS Final Rule (78 FR 50837–50853); FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50277–50286); FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49713–49723); FY 2017 IPPS/LTCH PPS Final Rule (81 FR 57182–57193); FY 2018 IPPS/LTCH PPS Final Rule (82 FR 38411–38425); FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41609–41624); FY 2020 IPPS/LTCH PPS Final Rule (84 FR 42509–42524); and FY 2021 IPPS/LTCH PPS Final Rule (85 FR 58959–58965).

Preview Period

Prior to publicly reporting data, hospitals are given the opportunity to review data during a 30-day preview period. The data anticipated for the release can be accessed via QualityNet, the only CMS-approved website for secure healthcare quality data exchange, located at <https://qualitynet.cms.gov/>.

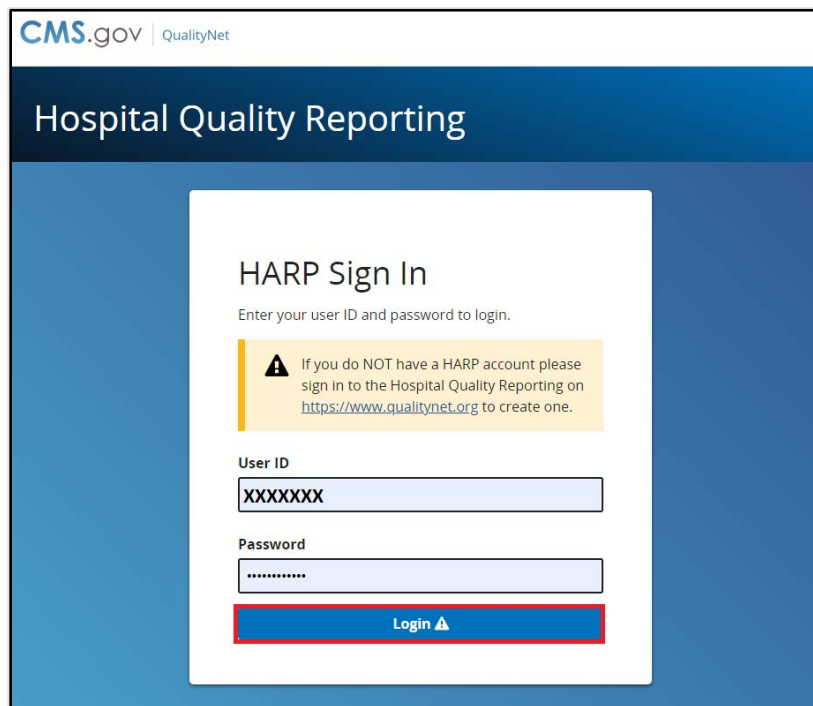
Public Reporting Preview User Interface (UI)

The Preview UI was developed to allow providers increased flexibility in reviewing their data.

Users must have a Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) account to access the user interface. If you do NOT have a HARP account, please sign in to the Hospital Quality Reporting (HQR) system on QualityNet (<https://qualitynet.cms.gov/>) to create one.

Follow the instructions below to access the UI:

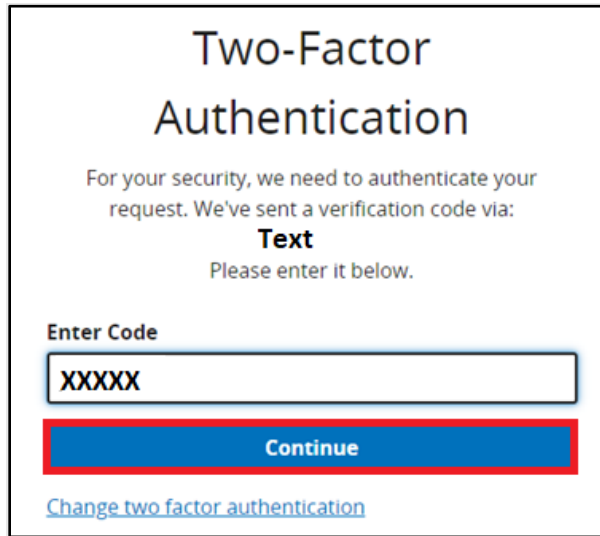
1. Access the Hospital Quality Reporting page on QualityNet at <https://hqr.cms.gov/hqrng/login>.
2. Enter your HARP User ID and Password. Then, select **Login**.



The screenshot shows the 'HARP Sign In' page within the 'Hospital Quality Reporting' section of the CMS.gov QualityNet portal. The page has a blue header with the CMS.gov logo and 'QualityNet' text. Below the header, the title 'Hospital Quality Reporting' is displayed. The main content area is white and contains the following elements:

- HARP Sign In** title
- Instruction: 'Enter your user ID and password to login.'
- A yellow warning box with a triangle icon: 'If you do NOT have a HARP account please sign in to the Hospital Quality Reporting on <https://www.qualitynet.org> to create one.'
- User ID** label above a text input field containing 'XXXXXXXX'.
- Password** label above a text input field containing '.....'.
- A blue 'Login' button with a small triangle icon.

3. You will be directed to the **Two-Factor Authorization** page. Select the device you would like to verify via **Text** or **Email**. Select **Continue**.
4. Once you receive the code via **Text** or **Email**, enter it. Select **Continue**.



Two-Factor Authentication

For your security, we need to authenticate your request. We've sent a verification code via:

Text

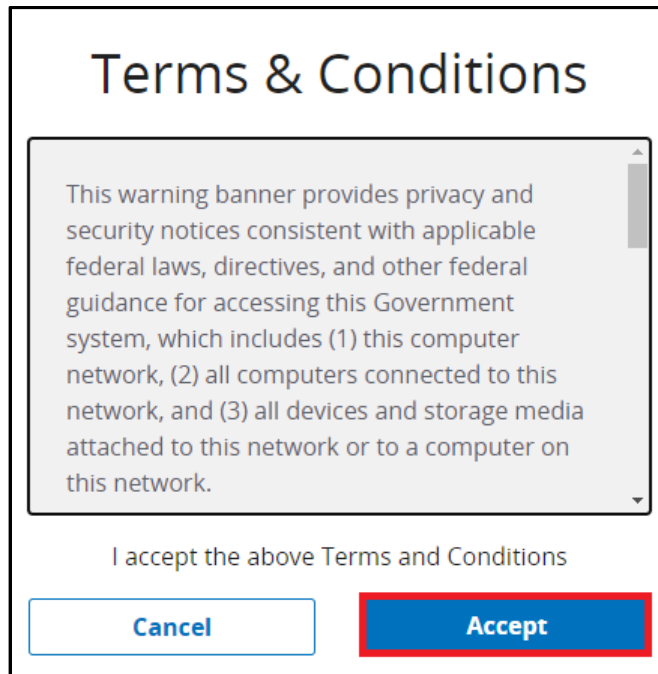
Please enter it below.

Enter Code

Continue

[Change two factor authentication](#)

5. Read the Terms and Conditions statement. Select **Accept** to proceed. You will see the **My Tasks** page. Note: If **Cancel** is selected, the program closes.



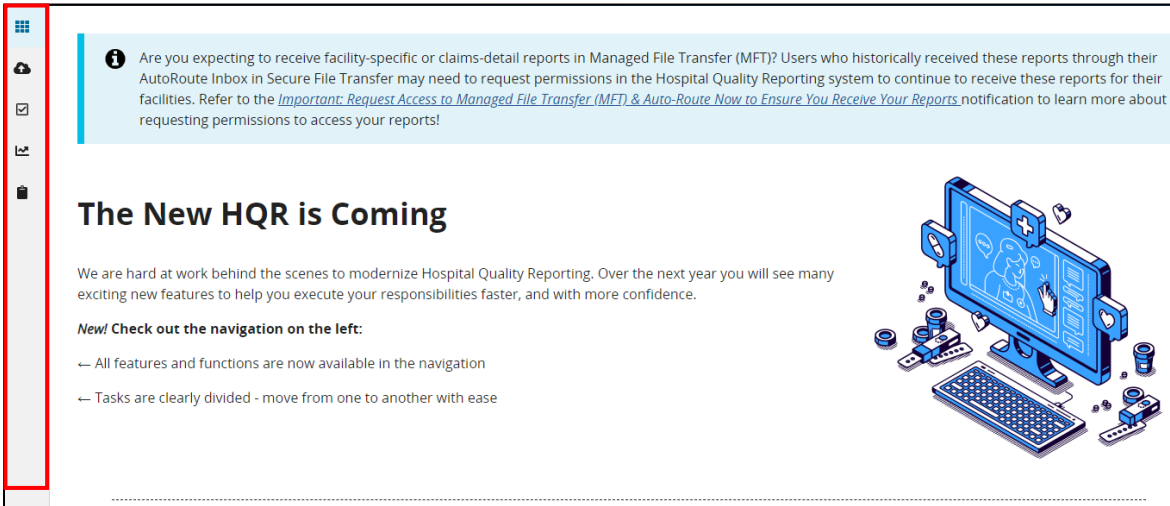
Terms & Conditions

This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes (1) this computer network, (2) all computers connected to this network, and (3) all devices and storage media attached to this network or to a computer on this network.

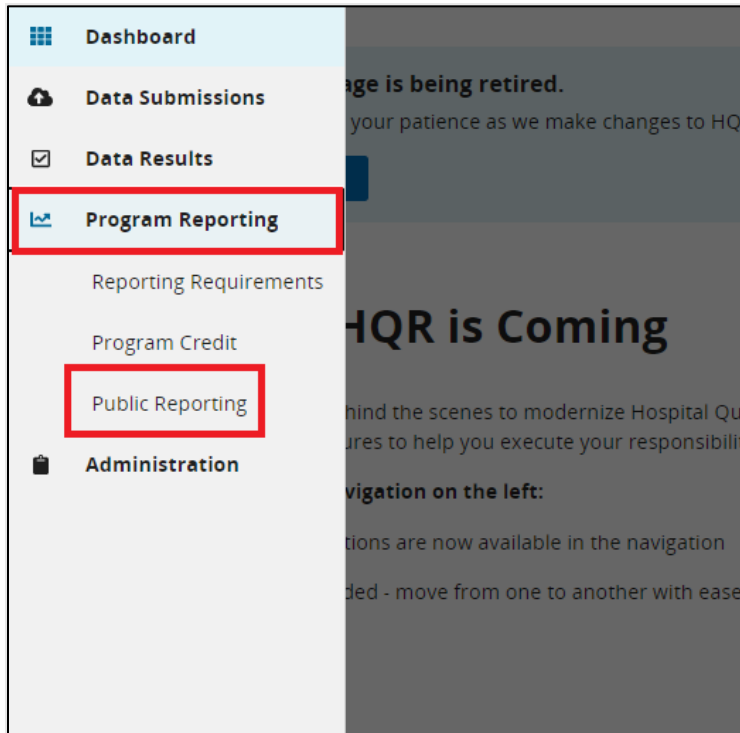
I accept the above Terms and Conditions

Cancel **Accept**

6. On the **HQR Landing** page, hover over the Lock Menu on the right side.

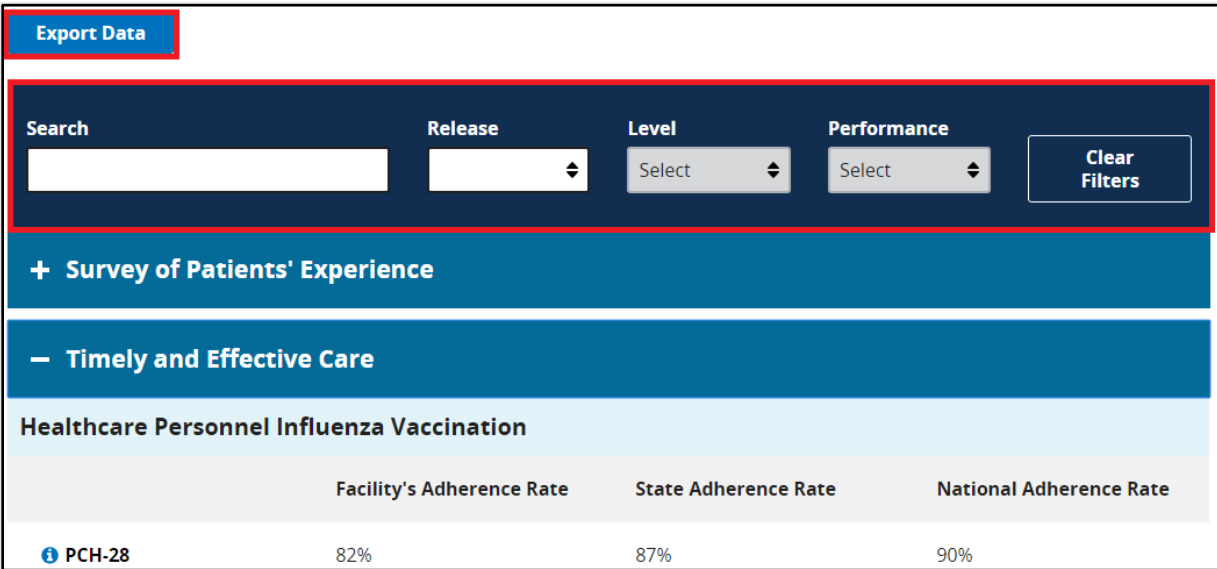


7. Select **Program Reporting**.



8. From the drop-down menu, select **Public Reporting**.
9. The page will refresh, and the data will be available to preview.
10. Your provider name and CMS Certification Number (CCN) will appear at the top of the Preview UI. The **Change Organization Button** is available to users with roles associated with multiple facilities to see a different provider's data.
11. There are two tabs: Measure Data and Star Rating.

12. Within the Preview UI, users will be able to easily view their data. This page is an interactive analogue to the traditional PDFs. On this page, users can view measures associated by Measure Group, search the entire page for individual measures, dynamically filter through data, and export measure data. The exported measure data will be in PDF format for a user-friendly printed report. Data will be retained following the 30-day preview for future reference.



Export Data - Users will be able to export measure data into a PDF format for a user-friendly printed report.

Search - Enter specific measures into this field and the table will dynamically filter for the appropriate content.

Filtering - Users will be able to filter their benchmark data in the following ways:

- Release - Select the release data to be viewed.
- Level - Filter whether your facility's data will be compared to the "State" or "National" average during filtering. This functionality is disabled currently and will be activated in a future release.
- Performance - Filter your facility's data for being "Above," "Below," or the "Same" as previous Level selections. This functionality is disabled currently and will be activated in a future release.

PR Data Details

Hospital Characteristics

The Preview UI PDF export displays your hospital CCN and name above the hospital characteristics. Hospital characteristics include your hospital's address, city, state, ZIP Code, phone number, county, type of facility, type of ownership, and emergency service provided status.

Type of ownership is publicly available only in the downloadable database on PDC.

If the displayed hospital characteristics are incorrect, your hospital should contact [your state Certification and Survey Provider Enhanced Reports \(CASPER\) agency coordinator](#) to correct the information. If your hospital's state CASPER agency is unable to make the needed change, your hospital should contact its [CMS regional office](#).

Rounding Rules

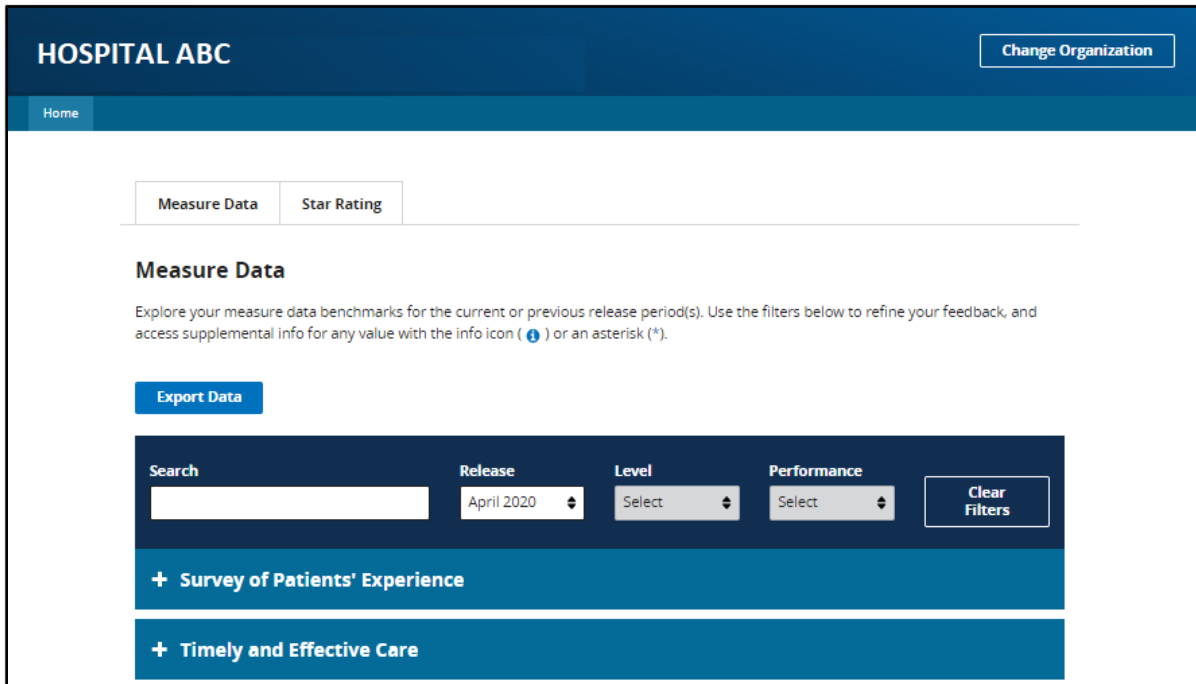
All percentage and median time calculations (provider, state, and national) are rounded to the nearest whole number using the following rounding logic, unless otherwise stated:

- Above [x.5], round up to the nearest whole number.
- Below [x.5], round down to the nearest whole number.
- Exactly [x.5] and "x" is an even number, round down to the nearest whole, even number. (Rounding to the even number is a statistically accepted methodology.)
- Exactly [x.5] and "x" is an odd number, round up to the nearest whole, even number. (Rounding to the even number is a statistically accepted methodology.)

PCH Preview Details

Measure Data Tab

The **Measure Data** tab will display accordions and measures based on the QualityNet access that the user has.



The accordions can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

+ Survey of Patients' Experience			
- Timely and Effective Care			
Healthcare Personnel Influenza Vaccination			
	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
i PCH-28	95%	81%	90%
+ Complications & Deaths			

Select the info icon ([i](#)) to the left of the measure ID to display the full measure description in a modal.

[✕ Close](#)

PCH-25: Details

Description:
External Beam Radiotherapy for Bone Metastases

Reporting Period:
Q1 (2019) - Q4 (2019)

[Cancel](#)

Data will display with an asterisk (*). Selecting the data value by the asterisk will pop up a modal with additional details about the data, such as a footnote.

	Facility Rate	Number of Patients
i PCH-25	97%*	100*

[✕ Close](#)

PCH-25 Facility Rate: Details

Footnote(s):
(2) - Data submitted were based on a sample of cases/patients.

[Cancel](#)

[✕ Close](#)

PCH-25 Number Of Patients: Details

Footnote(s):
(2) - Data submitted were based on a sample of cases/patients.

[Cancel](#)

Accordions

+SURVEY OF PATIENT'S EXPERIENCE

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient Experience Data (HCAHPS)

All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full annual payment update. All participating hospitals receive a preview report. Non-IPPS hospitals have the option of withholding HCAHPS results from being publicly reported on Care Compare. Hospitals participating in the Hospital IQR Program may not withhold HCAHPS results.

The HCAHPS Survey data contain survey results (normally from four quarters of data) that display as aggregate results. Each hospital's aggregate results are compared to state and national averages. Also, the preview data contain each hospital's number of completed surveys and survey response rate for the reporting period.

Note: CMS will not use data reflecting services provided January 1, 2020–June 30, 2020 (Q1 and Q2 2020) in its calculations for the Medicare quality reporting. For more information refer to this [Listserve](#).

The HCAHPS scores contained in the January 2022 public reporting Preview Report are based on patients discharged between July 1, 2020 through March 31, 2021.

The January 2022 HCAHPS scores are based on three quarters of data (Q3 2020, Q4 2020, and Q1 2021) rather than the customary four quarters. Please use caution when interpreting these HCAHPS scores as they are based on fewer months of data and fewer discharged patients than normal.

HCAHPS Star Ratings

HCAHPS Star Ratings are based on the quarters of survey data in the preview. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 10 HCAHPS measures plus the HCAHPS Summary Star Rating, which is a single summary of all the HCAHPS Star Ratings. The Preview data also contain the linear mean scores that are used in the calculation of the HCAHPS Star Ratings. For additional information on HCAHPS Star Ratings and linear mean scores, please see the HCAHPS Star Ratings section on the official HCAHPS website, <http://www.hcahponline.org>.

Note: Beginning with October 2019 public reporting, Composite 4 (Pain Communication) and the two associated individual questions (Q13 and Q14) was removed from the Public Reporting Preview UI. As a result, subsequent questions were renumbered and are consistent with the October 2019 survey questions. HCAHPS Composites, Individual Items, Global Items, and individual questions in the accordion include:

- HCAHPS Composites
 - Composite 1 – Communication with Nurses (Question Q1, Q2, Q3)
 - Q1 – Nurse Courtesy & Respect
 - Q2 – Nurse Listen
 - Q3 – Nurse Explain

- Composite 2 – Communication with Doctors (Q5, Q6, Q7)
 - Q5 – Doctor Courtesy & Respect
 - Q6 – Doctor Listen
 - Q7 – Doctor Explain
- Composite 3 – Responsiveness of Hospital Staff (Q4, Q11)
 - Q4 – Call Button
 - Q11 – Bathroom Help
- Composite 5 – Communication about Medicines (Q13, Q14)
 - Q13 – Medicine Explain
 - Q14 – Side Effects
- Hospital Environment Items
 - Cleanliness of Hospital Environment (Q8)
 - Quietness of Hospital Environment (Q9)
- Discharge Information Composite
 - Composite 6 – Discharge Information (Q16,Q17)
 - Q16 – Help After Discharge
 - Q17 – Symptoms
- Care Transition Composite
 - Composite 7 – Care Transition (Q20, Q21, Q22)
 - Q20 – Preferences
 - Q21 – Understanding
 - Q22 – Medicine Purpose

The HCAHPS Global Items include:

- Hospital Rating (Q18)
- Recommend this Hospital (Q19)

Hospitals must have at least 100 completed surveys in order to receive HCAHPS Star Ratings.

- HCAHPS Star Ratings are provided for each of the six composite measures, two environment items, and two global items.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 10 HCAHPS measures, plus the HCAHPS Summary Star Rating.

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the six composite measures, two environment items, and two global items. The scores are available in the downloadable database on [PDC](#).

Survey of Patients' Experience			
<p>Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.</p> <p>HCAHPS individual question scores based on fewer than 50 completed surveys will not be reported in the downloadable database.</p>			
HCAHPS Summary Star Rating			Q4 (2017) - Q3 (2018)
★★★★★			
Completed Surveys			1,164
Survey Response Rate			30%
<p>More Stars are better.</p> <p>*For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org</p> <p>**When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.</p>			
Communication with Nurses			Q4 (2017) - Q3 (2018)
★★★★★ Linear Score (1 - 100): 94			
Composite (Q1 - Q3)			
	Facility	State	National
Always	80%	76%	80%
Usually	14%	17%	16%
Sometimes/Never	2%	7%	4%
Nurse Courtesy & Respect (Q1)			
	Facility	State	National
Always	91%	83%	87%
Usually	8%	13%	10%
Sometimes/Never	1%	4%	3%

State and National Average Rates

State and national un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS Data Warehouse. State and national averages are not reported for the HCAHPS Star Ratings. The state and national averages include data from Department of Defense (DoD) hospitals and Veterans Health Administration (VHA) hospitals.

HCAHPS Individual Question Scores

Scores for the 15 individual questions on the HCAHPS Survey that are used to form the six HCAHPS composite measures will be included in the Public Reporting Preview UI.

- Hospitals must have at least 50 completed surveys for individual question scores to be shown in the downloadable database.
- HCAHPS individual question scores will NOT be reported on Care Compare.
- These individual question scores are included in the Preview UI and downloadable database:
 - Q1 – Nurse Courtesy & Respect
 - Q2 – Nurse Listen
 - Q3 – Nurse Explain
 - Q4 – Call Button
 - Q5 – Doctor Courtesy & Respect
 - Q6 – Doctor Listen
 - Q7 – Doctor Explain
 - Q11 – Bathroom Help
 - Q13 – Medicine Explain
 - Q14 – Side Effects
 - Q16 – Help After Discharge
 - Q17 – Symptoms
 - Q20 – Preferences
 - Q21 – Understanding
 - Q22 – Medicine Purpose

Note: HCAHPS individual question scores are presented for informational purposes only. They are not official HCAHPS measures. A simple average of the individual questions that comprise a composite measure may not match the composite score due to rounding, item weighting, and patient-mix adjustment.

+TIMELY AND EFFECTIVE CARE
 Healthcare Personnel Influenza Vaccination (PCH-28)

HEALTHCARE PERSONNEL INFLUENZA VACCINATION

HCP Influenza Vaccination (PCH-28) includes the number of healthcare workers contributing towards successful influenza vaccination adherence within the displayed time frame, regardless of clinical responsibility or patient contact.

The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare workers contributing to successful vaccination adherence divided by the total number of healthcare workers eligible to receive the influenza vaccine per the protocol of the National Healthcare Safety Network (NHSN) at the Centers for Disease Control and Prevention (CDC).

PCH-28 displays the following data:

- Facility’s Adherence Rate
- State Adherence Rate
- National Adherence Rate

Healthcare Personnel Influenza Vaccination			
	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
PCH-28	95%	81%	90%

FACILITY’S ADHERENCE RATE

Facility’s Adherence Rate is calculated as the total number of healthcare workers in your hospital contributing to successful vaccination adherence divided by the total number of healthcare workers in your hospital eligible to receive the influenza vaccine per NHSN protocol.

STATE ADHERENCE RATE

State Adherence Rate is calculated as the total number of healthcare workers in the state contributing to successful vaccination adherence divided by the total number of healthcare workers in the state eligible to receive the influenza vaccine per NHSN protocol.

NATIONAL ADHERENCE RATE

National Adherence Rate is calculated as the total number of healthcare workers in the nation contributing to successful vaccination adherence divided by the total number of healthcare workers in the nation eligible to receive the Influenza vaccine per NHSN protocol.

+COMPLICATIONS & DEATHS

Infections (PCH-6, PCH-7, PCH-26, PCH-27)

INFECTIONS MEASURES

Healthcare-Associated Infections (HAIs)

Hospitals submit HAI data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on [PDC](#).

Note: CMS will not use data reflecting services provided January 1, 2020–June 30, 2020 (Q1 and Q2 2020) in its calculations for the Medicare quality reporting. The HAI data for January 2022 measure rates reflect Q4 2019 and Q3 2020–Q1 2021 data. For more information please refer to this [Listserve](#).

The Infections Measures section of the Preview UI includes the following measures:

- PCH-06 Surgical Site Infection: Colon
- PCH-07 Surgical Site Infection: Abdominal Hysterectomy
- PCH-26 Clostridium difficile Infection (CDI)
- PCH-27 Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia

Measure Definitions

PCH-6 — Surgical Site Infections (SSI) for Colon Surgery

The SSI-Colon Surgery measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific colon surgeries performed for events identified within the displayed time frame. SSIs that were present at time of surgery (PATOS) are excluded.

PCH-7 — Surgical Site Infections for Abdominal Hysterectomy Surgery

The SSI-Abdominal Hysterectomy measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific abdominal hysterectomy surgeries performed for events identified within the displayed time frame. SSIs that were PATOS are excluded.

PCH-26 — Clostridium difficile (*C. difficile*) Infections

The *C. difficile* measure includes the number of hospital-onset *C. difficile* LabID events that occur in all inpatient locations, facility-wide **minus** neonatal ICUs, well-baby nurseries, or well-baby clinics within the displayed time frame.

PCH-27 — Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia Blood Infections

The MRSA bacteremia measure includes the number of hospital-onset MRSA bacteremia LabID events that occur in all inpatient locations facility-wide within the displayed time frame.

HAI MEASURE DISPLAY

As noted in the image below, HAI measure information is displayed in the following columns:

- Predicted
- Reported
- Days/Procedure
- Facility Ratio
- National Ratio
- National Compare

Infections							
	Predicted	Reported	Days / Procedure	Facility Ratio	State Ratio	National Ratio	National Compare
PCH-6	14,284	10	346	0.700 *	0.726 *	0.867	SAME
PCH-7	2,842	2	242	0.704 *	0.937 *	0.928	SAME
PCH-26	60,345	31	61,593	0.514 *	0.481 *	0.582	BETTER
PCH-27	9,631	7	61,593	0.727 *	1.063 *	0.821	SAME

PREDICTED

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.

REPORTED

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.

Any data submitted to NHSN after the CMS submission deadline will **not** be included in the data reported for the Preview or on [PDC](#).

Days/Procedure

PCH-6 (SSI-Colon): The procedure count field on this preview and on [PDC](#) displays the total number of in-plan, inpatient colon procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN’s Complex 30-day SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections. This procedure count may not match the procedure count shown on NHSN’s SIR Report, as NHSN’s SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link: <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

PCH-7 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on [PDC](#) displays the total number of in-plan, inpatient abdominal hysterectomy procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN’s Complex 30-day SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections.

This procedure count may not match the procedure count shown on NHSN’s SIR Report, as NHSN’s SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link:

<https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

PCH-26 (*C. difficile*): The total number of patient days in hospital facility-wide inpatient locations, minus neonatal ICUs, well-baby nurseries, or well-baby clinics in scope for quality reporting.

PCH-27 (MRSA): The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

Facility Ratio (SIR)

The SIR is a summary measure used to track HAIs at a facility 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.

The upper and lower confidence intervals for the facility ratio are provided in the associated modal by selecting the data next to the Facility Ratio. The modal lists your hospital’s lower-bound limit and upper-bound limit around the hospital’s SIR. The lower- and upper-bound limits of the confidence interval (95%) for your hospital’s SIR are an indication of precision and allow interpretation in terms of statistical significance.

When the lower limit of the confidence interval cannot be calculated due to the number of observed infections equaling zero, Footnote 8 is applied.

State Ratio

The State Ratio SIR is calculated by dividing the state numerator in scope for quality reporting by the state denominator in scope for quality reporting, for a specific infection type. The State Ratio will be provided on the Preview UI but will not be publicly displayed on [PDC](#).

National Ratio

The National Ratio SIR is based on current aggregated data in scope for quality reporting from acute care facilities to meet the CMS rule from the same time period as the facility’s data. It is shown to demonstrate where the most recent overall national SIR stands. This ratio is not shown on [PDC](#) to avoid confusion with the National SIR Benchmark used to compare hospital performance.

National Comparison

Your hospital’s performance phrase is determined by comparing your facility’s SIR to a national benchmark of 1. A confidence interval with a lower and upper limit is displayed around each SIR to indicate a high degree of confidence (95%) that the true value of the SIR lies within that interval.

Performance phrases displayed are:

- **Better** (Better than the National Benchmark): Displays if your hospital’s SIR has an upper limit that is less than the National Benchmark of one
- **Same** (No Different than National Benchmark): Displays if your hospital’s SIR has a confidence interval (lower to upper limit) that includes the National Benchmark of one
- **Worse** (Worse than the National Benchmark): Displays if your hospital’s SIR has a lower limit that is greater than the National Benchmark of one.

+UNPLANNED HOSPITAL VISITS

Procedure Specific Outcomes (PCH-30, PCH-31)

PROCEDURE SPECIFIC OUTCOMES MEASURES

Note: CMS will not use data reflecting services provided January 1, 2020–June 30, 2020 (Q1 and Q2 2020) in its calculations for the Medicare quality reporting. For more information refer to this [Listserve](#).

The Procedure Specific Measures section of the Preview UI includes the following measures:

- PCH-30 Admission Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Admission Rate
- PCH-31 Emergency Department Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Emergency Department Visits Rate

– Unplanned Hospital Visits				
Admissions and ED Visits				
	Eligible Discharges	Facility Rate	National Rate	National Compare
PCH-30	7,121	13%*	14.3%*	SAME
PCH-31	7,121	7.4%*	6.5%*	SAME

PROCEDURE SPECIFIC OUTCOMES DETAILS

The Preview UI displays four quarters of data. The data are updated annually in July. Each measure displays:

- Eligible Cases
- Facility Rate/ Ratio
- National Rate/ Ratio
- National Compare

+PROCESS MEASURES

Oncology Care (PCH-15)

ONCOLOGY CARE MEASURE

The Oncology Care Measure (OCM) section of the Preview UI includes PCH-15 Oncology: Medical and Radiation - Plan of Care for Moderate to Severe Pain.

Oncology Care		
	Facility Rate	Number of Patients
i PCH-15	N/A *	N/A *

ONCOLOGY CARE MEASURE DETAILS

The Preview UI displays an aggregate of four quarters of data. The OCM data are updated annually. Each measure displays:

- Facility Rate
- Number of Patients

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient’s Experience	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness of Hospital Environment Quietness of Hospital Environment Discharge Information Care Transition Hospital Rating Recommend this Hospital
Timely and Effective Care	Sepsis (SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR) Emergency Department (OP-18b, OP-18c, OP-22, OP-23) Healthcare Personnel Influenza Vaccination (IMM-3, PCH-28) Perinatal Care (PC-01) Cardiac Care (OP-2, OP-3b) Cataract (OP-31) Colonoscopy (OP-29)
Complications & Deaths	30-Day Death Rates (MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG) CMS Patient Safety Indicators (PSI-3, PSI-4, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14, PSI-15, PSI-90) Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6, PCH-6, PCH-7, PCH-26, PCH-27) Surgical Complications (Comp-HIP-KNEE)
Unplanned Hospital Visits	Condition Specific Readmission (READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD) Procedure Specific Readmission (READM-30-CABG, READM-30-HIP-KNEE) Hospital Wide Readmission (READM-30-HOSPWIDE) Inpatient Psychiatric Facility Readmission (READM-30-IPF) Procedure Specific Outcomes (PCH-30, PCH-31, OP-32, OP-35 ADM, OP-35 ED, OP-36) Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)

Measure Accordion	Measure IDs Included
Payment & Value of Care	Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE) Medicare Spending per Beneficiary (MSPB-1)
Follow-Up Care	Transition Record (TR1, TR2) Hospital-Based Inpatient Psychiatric Services (HBIPS-5) Follow-Up After Hospitalization for Mental Illness (FUH-7, FUH-30) Medication Continuation Following Inpatient Psychiatric Discharge (MedCont)
Substance Use Treatment	Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (TOB-2, TOB-2a, TOB-3, TOB-3a)
Patient Safety	Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3)
Preventative Care and Screening	Screening (SMD) Immunization (IPFQR-IMM-2)
Use of Medical Imaging	Imaging Efficiency (OP-8, OP-10, OP-13)
Process Measures	Oncology Care (PCH-15)

Footnote Table

Number	Description	Application
1	The number of cases/patients is too few to report.	<p>Applied to any measure rate where the denominators are greater than zero and less than eleven. Data will not display on PDC.</p> <p>For HCAHPS:</p> <ul style="list-style-type: none"> • This is applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges. • HCAHPS scores based on fewer than 25 completed surveys will display on the Preview UI. • Data will not display on PDC. • Measures based on claims data: Applied to any hospital where the number of cases reported is too small (less than 25 and greater than zero) to reliably tell how well a hospital is performing.
3	Results are based on a shorter time period than required.	Applied when CMS has opted to display HCAHPS Survey results on fewer than the required months of survey data.
4	Data suppressed by CMS for one or more quarters.	Reserved for CMS use.
5	Results are not available for this reporting period.	<p>Applied when a hospital either elected not to submit data or the hospital had no data to submit for a particular measure or when a hospital elected to suppress a measure.</p> <p>For HCAHPS:</p> <ul style="list-style-type: none"> • When a hospital did not participate in HCAHPS reporting during the period covered by the applicable Preview UI • When a hospital only participated in HCAHPS reporting for a portion of the period covered by the applicable Preview UI • When a hospital chooses to suppress HCAHPS results (A hospital will see HCAHPS results on its Preview UI, but not on PDC.)

Number	Description	Application
6	Fewer than 100 patients completed the HCAHPS Survey. (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS Surveys is 50–99.
7	No cases met the criteria for this measure	Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
10	Very few patients were eligible for the HCAHPS Survey. The scores shown reflect fewer than 50 completed surveys. (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS Surveys is fewer than 50.
11	There were discrepancies in the data collection process.	Applied when there have been deviations from HCAHPS data collection protocols.
15	The number of cases/patients is too few to report an HCAHPS Star Rating.	Applied when CMS has determined there are too few cases or patients to report a star rating.
28	The data are based on the hospital or facility has submitted to CMS. The hospital or facility has submitted an Extraordinary Circumstances Request suggesting results may be impacted by the COVID-19 pandemic.	This footnote is applied when a hospital or facility alerts CMS of a possible concern with data used to calculate the results of this measure via an approved Extraordinary Circumstances Exception form. Calculated values should be used with caution.

Resources

Note: Questions should be directed to the subject matter experts listed below.

TIMELY AND EFFECTIVE CARE MEASURE, COMPLICATIONS AND DEATH MEASURES, PROCEDURE-SPECIFIC OUTCOME MEASURES

Please direct questions to the [QualityNet Question and Answer Tool](#).

OCM MEASURE

Contact the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contract Team via the [QualityNet Question and Answer Tool](#) or call (844) 472-4477 or (866) 800-8765 weekdays from 8 a.m. to 8 p.m. ET.

HCAHPS MEASURES

Contact the HCAHPS Project Team by email at hcahps@hsag.com