Public Reporting Preview Help Guide

Hospitals, inpatient psychiatric facilities, rural emergency hospitals and their quality reporting staff are the target audience for this publication.

The document scope is limited to instructions for facilities and hospitals to access and understand data provided on the public reporting user interface prior to publication on the Compare tool on Medicare.gov. and/or the Data Catalog on data.cms.gov

November 2026 Public Reporting Preview/January 2027 Public Reporting Release

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Overview

Compare Tool on Medicare.gov

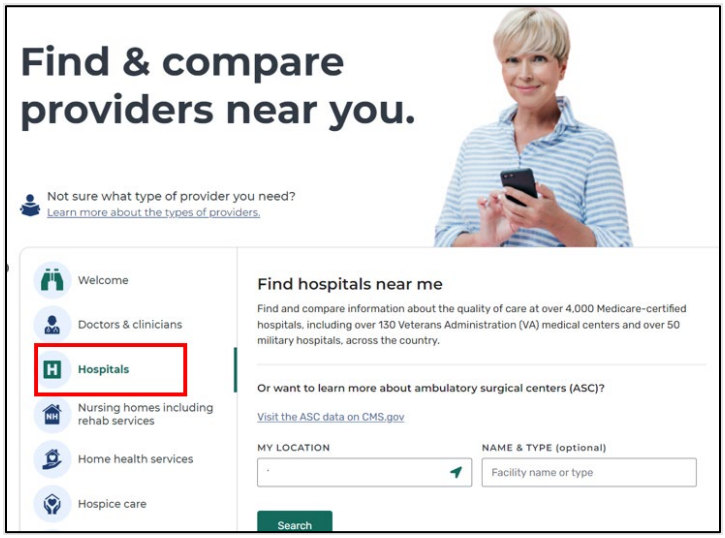
CMS and the nation's hospitals and inpatient psychiatric facilities (IPFs) work collaboratively to publicly report hospital and IPF quality performance information on the Compare tool on Medicare.gov and the Data Catalog on data.cms.gov.

The Compare tool on Medicare.gov displays hospital and IPF performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in hospitals and IPFs.

The Data Catalog on data.cms.gov provides direct access to the CMS official data that are used on the Compare tool on Medicare.gov website and directories.

Navigating to the Compare tool on Medicare.gov.

1. From the left column of the home page, select Hospital.



2. On the home page, you may enter your ZIP code. Select Search.
3. Select up to three providers from the list to view the data.

Navigating to the Data Catalog on data.cms.gov

1. Select *Hospitals* on the home page.
2. Search for specific data set.
3. Instructions on how to download a dataset can be found at this link: https://data.cms.gov/provider-data/about#download-a-dataset

Preview Period

Hospitals and facilities are given the opportunity to preview their data 30 days before the data are publicly displayed on the Compare tool at Medicare.gov. The data that CMS anticipate to release can be accessed via the Hospital Quality Reporting (HQR) system page at https://hqr.cms.gov/hqrng/login.

Measure Data Tab

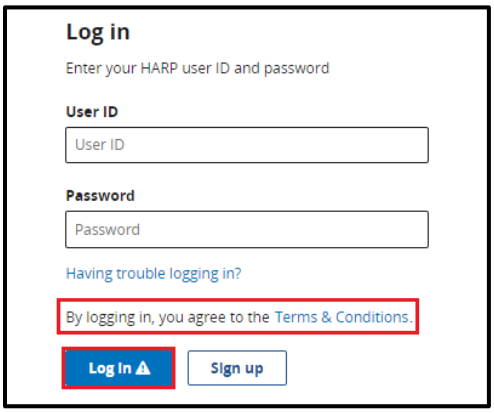
Public Reporting Preview User Interface (UI)

The Preview UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to the Compare tool on Medicare.gov.

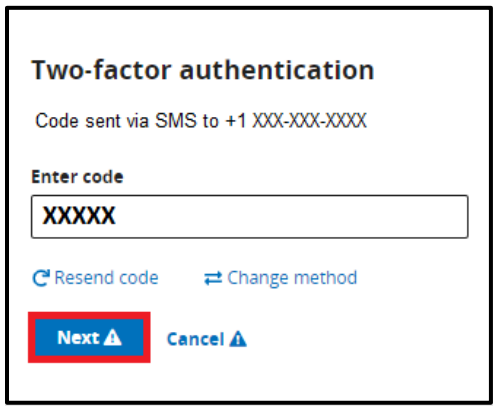
Users must have a Health Care Quality Information Systems Access Roles and Profile (HARP) account in order to access the Preview UI. If you do not have a HARP account, you may register for a HARP ID.

Follow the instructions below to access the Preview UI:

1. Access the HQR system page for QualityNet at https://hqr.cms.gov/hqrng/login.
2. Enter your HARP User ID and Password. By logging in, you agree to the terms and conditions. Then, select **Log In**.



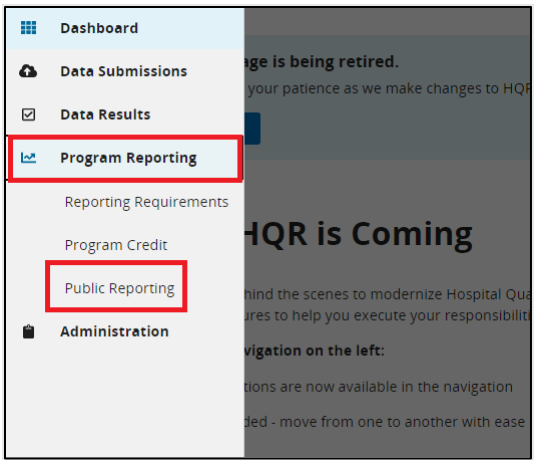
3. You will be directed to the **Two-Factor Authorization** page. Select the device you would like to verify via **Text** or **Email.** Select **Next**.
4. Once you receive the code via **Text** or **Email**, enter it. Select **Next**.



5. On the **HQR** system landing page, scroll to the bottom of the page and hover over the *Lock Menu* on the left side.



6. Select **Program Reporting.** From the drop-down menu, select **Public Reporting.** The page will refresh, and the data will be available to preview.



7. Your provider name 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.
8. There are three tabs: **Measure Data**, **Star Rating** and **Promoting Interoperability Program**.



Navigation Tips

The **Measure Data** tab will display accordions and measures based on the user's HQR system portal access.



The accordions are labeled similarly to the sections on the Compare tool on Medicare.gov and 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.

Select the info icon ( ) to the left of the measure ID to display the full measures description in a modal.

If the data are displayed with an asterisk (*), select the data value by the asterisk to open a modal with additional details about the data (such as a footnote).

Hospital Characteristics

The Preview UI PDF export displays the hospital or facility CMS Certification Number (CCN) and name above the hospital characteristics. Hospital characteristics include the hospital or facility'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 the Data Catalog on data.cms.gov.

If the displayed hospital or facility characteristics are incorrect, staff should send an email to the ServiceNow Help desk at qnetsupport@cms.hhs.gov with information regarding the error and the specific information that should be included for their hospital or facility. Submitted corrections may require time to resolve and may not be reflected in the next Compare refresh.

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.)

Programs

Inpatient Hospital Measures

Accordions

+Survey of Patients Experience – Hospital Inpatient
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

The HCAHPS Survey data display aggregate results. Each hospital's aggregate results are compared to state and national averages. The preview data also includes each hospital's total number of completed surveys and survey response rate for the reporting period. HCAHPS data are updated quarterly with each public reporting release.

HCAHPS Star Ratings are based on the quarters of survey data included in the preview. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 11 HCAHPS measures and the HCAHPS Summary Star Rating, which is a single summary statistic of all the HCAHPS Star Ratings. The Preview dataset also contains 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: https://hcahpsonline.org/en/hcahps-star-ratings/.

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

- HCAHPS Star Ratings are provided for each of the seven composite measures, two individual items, and two global items.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 11 HCAHPS measures, plus the HCAHPS Summary Star Rating.

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the seven composite measures, two individual items, and two global items. The scores are available in the downloadable database on the Data Catalog on data.cms.gov.

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.

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 participating Department of Defense (DoD) and Veterans Health Administration (VHA) hospitals.

+Timely and Effective Care
Sepsis (SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR)
Healthcare Personnel Vaccination (IMM-3)
Opioid Use (Safe Use of Opioids—Concurrent Prescribing)

Venous Thromboembolism (VTE-1, VTE-2)
Stroke Care (STK-02, STK-03, STK-05)
Hospital Harm (HH-AKI, HH-HYPO, HH-HYPER, HH-ORAE, HH-PI)
Excessive Radiation (IP-ExRad)
Malnutrition Care Score (MCS)
Age Friendly Hospital (AFH)
Patient Safety Structural Measure (PSSM)

Sepsis

SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR

The Severe Sepsis and Septic Shock Management Bundle (Sepsis [SEP-1]) measure three-hour and six-hour bundles are displayed for Severe Sepsis and for Septic Shock. The data in the bundles match the reporting quarters of the overall SEP-1 measure. The bundles are included in the Timely and Effective Care downloadable databases available on the Data Catalog on data.cms.gov. These measures are updated with each of the quarterly public reporting releases.

Chart-abstracted measure data display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

Denominators greater than 0 and less than 11 will display on the Preview UI but not on the Compare tool on Medicare.gov.

The state and national rates are calculated based on the data in the CMS Clinical Data Warehouse, regardless of whether the hospital elected to opt out of publicly reporting data on the Compare tool on Medicare.gov.

Healthcare Personnel (HCP) Vaccination Measure

Influenza Vaccination

HCP Influenza Vaccination (IMM-3) includes the number of HCP contributing towards successful influenza vaccination adherence within the displayed time frame (October 1 through March 31), regardless of clinical responsibility or patient contact. Facilities report data through the National Healthcare Safety Network (NHSN) once each influenza season. This measure is updated annually during the October public reporting release.

IMM-3 displays the following data:

- Facility's Adherence Rate
- State Adherence Rate
- National Adherence Rate

Facility's Adherence Rate

The **IMM-3 Adherence Percentage** is calculated as the total number of HCP contributing to successful influenza vaccination adherence (the number of HCP who were vaccinated at the facility or provided written documentation of vaccination elsewhere), divided by the total number of HCP who physically worked in the facility for at least one working day between October 1 through March 31 per the CDC's NHSN protocol.

State Adherence Rates are calculated as the total number of HCP in the state contributing to successful vaccination adherence divided by the total number of HCP in the state.

National Adherence Rates are calculated as the total number of HCP in the nation contributing to successful vaccination adherence divided by the total number of HCP in the nation.

eCQMs

These eCQMs are included in the Timely and Effective Accordion:

- Safe Use of Opioids: Safe Use of Opioids—Concurrent Prescribing
- VTE-1: Venous Thromboembolism Prophylaxis
- VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
- STK-02: Discharged on Antithrombotic Therapy
- STK-03: Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-05: Antithrombotic Therapy by End of Hospital Day 2
- *HH-AKI: Hospital Harm-Acute Kidney Injury
- HH-HYPO: Hospital Harm-Severe Hypoglycemia
- HH-HYPER: Hospital Harm-Severe Hyperglycemia
- HH-ORAE: Hospital Harm-Opioid Related Adverse Events
- HH-PI: Hospital Harm-Pressure Injury
- IP-ExRad: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults
- MCS: Malnutrition Care Score

The eCQM data results are an aggregate of four quarters of data, calculated from data submitted via certified electronic health record (EHR) technology (CEHRT) and are updated annually during the October public reporting release. The eCQMs display facility, state and national data; however, the data varies by measure.

Data display:

- Facility Rate or Ratio
- Number of Patients or Encounters
- State Rate or State Ratio
- National Rate or National Ratio
- Top 10% or Top 10% Ratio

*HH-AKI is risk-adjusted and displays:

- Facility Risk-Adjusted Rate
- Number of Encounters
- State Rate
- National Rate

The **facility level data** displayed on the preview report will **only** be included in the Timely and Effective Care downloadable databases on the data catalog on data.cms.gov. Denominators greater than 0 and less than 25 will display on the Preview UI but not on the data catalog on data.cms.gov.

The **state and national performance rates** displayed on the preview report are for informational purposes CMS will not publicly report the state and national performance rates at this time.

Note: Safe Use of Opioids—Concurrent Prescribing measure will display facility, state, and national level data on both the data catalog on data.cms.gov and the Compare tool on Medicare.gov. For additional information**,** please visit this website: https://oncprojectracking.healthit.gov/support/browse/EKI-21

Age Friendly Hospital Measure

Data display the number of affirmative responses the hospital entered via a web-based tool to five attestation domain statements. The maximum score for a facility is 5.

The data display the following:

- Total Hospital Score
- Number and percentage of hospitals in the state and nation for each of the possible scores

Patient Safety Structural Measure (PSSM)

Data display a score of 0-5 based on hospital attestation that assessed whether hospitals demonstrated having a structure and culture that prioritizes patient safety.

The data display the following:

- Total Hospital Score
- Number and percentage of hospitals in the state and nation that received each of the possible scores

+Maternal Health
Maternal Morbidity Structural Measure (SM-7) Perinatal Care (PC-02, PC-07a, PC-07b)

Maternal Morbidity

The Maternal Morbidity Structural Measure displays the hospitals response to this question: "Does your hospital or health system participate in a statewide and/or national perinatal quality improvement collaborative program aimed at improving maternal outcomes during inpatient labor, delivery, and post-partum care, and has it implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?"

Data display response options:

- Yes
- No
- Not Applicable

Note: "Not Applicable" indicates the hospital does not provide inpatient labor/delivery care.

Hospitals who submitted the response "Yes" will have a "Birthing Friendly" logo displayed on the Compare tool on Medicare.gov site. The Maternal Morbidity Structural Measure (SM-7) is included in the Maternal Health – Hospital downloadable database on the Data Catalog on data.cms.gov.

Perinatal Care eCQMs

Perinatal Care eCQMs include the following:

- PC-02: Cesarean Birth
- PC-07a: Severe Obstetric Complications
- PC-07b: Severe Obstetric Complications without Blood Transfusions

These measures display four quarters of data, displayed as an aggregate rate, calculated from data submitted via an EHR. The data will be updated annually in October based on data submitted as of the eCQM submission deadline. Denominators greater than 0 and less than 25 will display on the Preview UI but not in the Data Catalog on data.cms.gov.

SM-7, PC-02, PC-07a, and PC-07b are displayed in the Maternal Health on the Data Catalog on data.cms.gov and on the Compare tool on Medicare.gov.

PC-02 displays:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rate** is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state. These rates are provided for informational purposes and will not be publicly reported at this time.

The **national performance rate** is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation. These rates are provided for informational purposes and will not be publicly reported at this time.

The **90th percentile** is calculated for each measure using the un-weighted average or median for each eligible hospital and identifying the top 10% of hospitals. These rates are for informational purposes and will not be publicly reported at this time.

PC-07a and **PC-07b** are risk-adjusted measures and display:

- Facility risk-adjusted rate (per 10,000)
- Number of Patients
- State Rate (per 10,000)
- National Rate (10,000)
- National Compare

Beginning with October 2026 reporting, performance categories will be included alongside the risk-standardized measure results for hospitals with ≥25 eligible delivery hospitalizations:

- Top Performer (Top 25%)
- Middle Performer (Middle 50%)
- Bottom Performer (Bottom 25%)

Hospitals with lower risk standardized scores are considered top performers since lower scores are better, and hospitals with higher risk standardized scores are considered bottom performers. For hospitals with fewer than 25 eligible delivery hospitalizations, hospitals are included in a separate category (too few cases).

Hospital-Specific Reports (HSRs) are available to hospitals via the HQR system and provide additional details on hospital performance and national risk-adjusted rates for PC-07a and PC-07b measures.

+Complications & Deaths
30 Day Death Rates (Hybrid HWM, MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG)
CMS Patient Safety Measures (PSI 03, PSI 06, PSI 08, PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, PSI 15, PSI 90, ISCMR)
Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6)
Surgical Complications (COMP-HIP-KNEE)

30-Day Death Rate

Hybrid HWM, MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG

The 30-Day mortality measures, also referred to as the 30-Day Risk-Standardized Mortality measures, are typically updated annually during the July public reporting release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

- With the exceptions of the Hybrid Hospital-Wide Mortality measure, which is calculated using 12 months of data, and the MORT-30-STK measure that uses 24 months of data, the measures are calculated using 36 months of data.
- Hospitals with fewer than 25 eligible cases for the mortality measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing." Data from these hospitals are included in the measure calculations but will not be reported on the Compare tool on Medicare.gov.

These measures include the following:

- Hybrid HWM: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate
- MORT-30-AMI: Acute Myocardial Infarction (AMI) Mortality Rate
- MORT-30-HR: Heart Failure (HF) 30-Day Mortality Rate
- MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
- MORT-30-STK: Acute Ischemic Stroke (STK) 30-Day Mortality Rate
- MORT-30-COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate

- MORT-30-CABG:30-Day All-Cause Mortality Following Coronary Artery By-Pass Graft (CABG) Surgery

30 Day mortality measures display the following data:

- Eligible [Medicare] Discharges
- Facility Rate/Value
- National Rate/Value
- National Compare*

***Note:** The national compare values and confidence intervals are currently suppressed and display 'Not Available' for these measures and will continue to be suppressed until the July 2027 Public Reporting Preview Report and release. Individual hospital measure rates were not impacted.

HSRs are available to hospitals via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for all the mortality measures.

CMS Patient Safety Measures

PSI 03, PSI 06, PSI 08, PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, PSI 15, PSI 90, ISCMR

Participating hospitals are included in the calculation of the CMS PSI measures and the Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) The following CMS patient safety measures are reported on the Compare tool on Medicare.gov:

- ICSMR Inpatient Surgical Complications Mortality Rate
- CMS PSI 90 Patient safety and adverse events composite

The ten individual components of the CMS PSI 90 composite measure include:

- PSI 03 Pressure ulcer rate
- PSI 06 Iatrogenic pneumothorax rate
- PSI 08 In-hospital fall-associated fracture rate
- PSI 09 Postoperative hemorrhage or hematoma rate
- PSI 10 Postoperative acute kidney injury requiring dialysis rate
- PSI 11 Postoperative respiratory failure rate
- PSI 12 Perioperative pulmonary embolism or deep vein thrombosis rate
- PSI 13 Postoperative sepsis rate
- PSI 14 Postoperative wound dehiscence rate
- PSI 15 Abdominopelvic accidental puncture or laceration rate

The CMS PSI 90 measure and the ISCMR measure results are reported on the Compare tool on Medicare.gov.

However, the measure results for the component measures of CMS PSI 90 are only publicly reported in the downloadable datasets on the Data Catalog on data.cms.gov. These measures are updated annually during the July public reporting release. (PSI measure results for 2026 public reporting will be updated on PDC and Care Compare in the October 2026 release.)

The datasets on Data Catalog on data.cms.gov display the following:

- Eligible [Medicare] Discharges (except for the CMS PSI 90 composite)
- Facility Rate/Value (per 1,000 discharges)
- The 95% Confidence Interval Estimates of each Facility's CMS Patient Safety Measure Rate/Value
- National Rate/Value
- Comparison to the National Rate/Value
- The number of hospitals in the state and the nation in each performance category

Hospitals' performance is categorized as; Better Than, No Different Than, or Worse Than the National Rate/Value. "Number of cases too small" is used when there are too few cases to reliably tell how well the hospital is performing on an individual CMS Patient Safety measures. For the ISCMR measure, hospitals with fewer than 25 eligible discharges are assigned to "Number of cases too small". For the individual CMS PSI 90 component measures, hospitals with three to 24 eligible discharges are assigned to "Number of cases too small", while hospitals with fewer than three eligible discharges are assigned "N/A" for the performance category. For the PSI 90 Composite, hospitals that do not have at least one component measures with 25 or more eligible discharges and at least 7 component measures with 3 or more eligible discharges will be assigned "N/A" for the performance category.

HSRs are available to hospitals via the HQR system and provide additional details on hospital performance and national risk-adjusted rates for all the Patient Safety measures.

Healthcare-Associated Infections (HAIs)

HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6

HAI Measures

The HAI section of the Preview UI includes the following measures:

- HAI-1: Central Line-associated Bloodstream Infection (CLABSI)
- HAI-2: Catheter-associated Urinary Tract Infection (CAUTI)
- HAI-3: Surgical Site Infections for Colon Surgery
- HAI-4: Surgical Site Infections for Abdominal Hysterectomy Surgery
- HAI-5: Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia Blood Infections
- HAI-6: *Clostridium difficile* (C. difficile) Infections

Hospitals submit HAI data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on the Compare tool on Medicare.gov. These measures are updated each of quarterly public reporting releases.

HAI Measure Display

HAI measure information is displayed in the following columns:

- Predicted
- Reported
- Days/Procedure
- Facility Ratio
- State Ratio

- National Ratio
- National Compare

Predicted

Hospitals 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 2022 (resulting in the updated Standardized Infection Ratio (SIR) baseline described above) and is risk adjusted for the hospital based on several factors. The predicted number of infections is used by NHSN as the denominator to calculate the hospital's SIR.

Reported

Hospital's reported number of infections is the observed number of infections reported by the hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate the 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 the Compare tool on Medicare.gov.

Days / Procedure

HAI-1 (CLABSI): The number of central line days in hospital locations in scope (adult, pediatric, and neonatal ICUs, and selected wards) for quality reporting.

HAI-2 (CAUTI): The number of urinary catheter days in hospital locations in scope (adult and pediatric ICUs and selected wards) for quality reporting.

HAI-3 (SSI-Colon): The procedure count field on this preview and on the Compare tool on Medicare.gov 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 Surgical Site Infection (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/2022rebaseline/sir-guide.pdf

HAI-4 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on the Compare tool on Medicare.gov 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/2022rebaseline/sir-guide.pdf

HAI-5 (MRSA): The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

HAI-6 (*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.

Facility Ratio 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 the hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/2022rebaseline/sir-guide.pdf

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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 and state ratios are provided in the associated modal by selecting the data next to the Facility Ratio or the State Ratio. The modal lists the 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 the 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.

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 **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 the Compare tool on Medicare.gov to avoid confusion with the National SIR Benchmark used to compare hospital performance.

National Comparison

The hospital's performance phrase is determined by comparing the 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 the hospital's SIR has an upper limit that is less than the National Benchmark of one
- **Same** (No Different than National Benchmark): Displays if the 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 the hospital's SIR has a lower limit that is greater than the National Benchmark of one

Surgical Complications

COMP-HIP-KNEE – Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) surgical complication measure is reported on the Compare tool on Medicare.gov.

This risk-standardized complication measure is typically updated annually during the July public reporting release. The surgical complications portion of the expanded accordion displays the RSCR Following Elective Primary THA and/or TKA measure. This measure is also referred to as the THA/TKA Complication measure. Hospitals are not required to submit these data because CMS calculates the measure from claims and enrollment data. The measure is calculated using 24 months of data.

Hospitals with fewer than 25 eligible cases for the THA/TKA Complication measure are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on the Compare tool on Medicare.gov.

The Complication measure display includes the following data:

- Eligible [Medicare] Discharges
- Complication Rate/Value
- National Rate/Value
- National Compare*

***Note:** The national compare values and confidence intervals are currently suppressed and display 'Not Available' for this measure and will continue to be suppressed until the July 2027 Public Reporting Preview Report and release. Individual hospital measure rates were not impacted.

HSRs are available to hospitals via the HQR system. They provide average state risk-standardized outcome rates and national-observed (unadjusted) rates for the Complication measure.

+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 (Hybrid HWR)
Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)

Condition Specific, Procedure Specific and Hospital Wide Readmissions

READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD, READM-30-CABG, READM-30-HIP-KNEE, Hybrid HWR

The 30-Day Risk-Standardized Readmission Measures are typically updated annually during the July public reporting release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

- With the exception of the Hospital-Wide Readmission measure, which is calculated using 12 months of data, the measures are all calculated using 24 months of data.
- Hospitals with fewer than 25 eligible cases for the readmission measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on the Compare tool on Medicare.gov.

The Readmission measures include the following:

- READM-30-AMI: Acute Myocardial Infarction (AMI) Readmission Rate
- READM-30-HF: Heart Failure (HF) 30-Day Readmission Rate
- READM-30-PN: Pneumonia (PN) 30-Day Readmission Rate
- READM-30-COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate
- READM-30-CABG: Hospital-Level 30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)
- READM-30-HIP-KNEE: 30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
- Hybrid HWR: Hybrid Hospital-Wide All-Cause Readmission Rate

The readmission measures display:

- Eligible [Medicare] Discharges
- Facility Rate/Value
- National Rate/Value
- National Compare*

***Note:** The national compare values and confidence intervals are currently suppressed and display 'Not Available' for these measures and will continue to be suppressed until the July 2027 Public Reporting Preview Report and release. Individual hospital measure rates were not impacted.

HSRs are available to hospitals via the HQR system. They provide average state risk-standardized outcome rates and national-observed (unadjusted) rates for the Readmission measures.

Excess Days in Acute Care

EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN

The Excess Days in Acute Care (EDAC) measures are typically updated annually during the July public reporting release.

Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

- The measures are calculated using 36 months of data.
- The Compare tool on Medicare.gov will report EDAC as Hospital Return Days measures.
- Hospitals with fewer than 25 eligible cases for the EDAC measures (50 cases for AMI EDAC) are assigned to a separate category described as "the number of cases is too small to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on the Compare tool on Medicare.gov.
- The EDAC measures incorporate the time spent in acute care (ED visits, observation stays, and unplanned readmissions) after discharge from the hospital.

The EDAC measures include the following:

- EDAC-30-AMI Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
- EDAC-30-HF Excess Days in Acute Care after Hospitalization after Hospitalization for Heart Failure
- EDAC-30-PN Excess Days in Acute Care after Hospitalization after Hospitalization for Pneumonia

EDAC measures display:

- Eligible [Medicare] Discharges
- Patients Included (number of patients included in the EDAC measure)
- Returning to a Hospital (number of patients who returned to a hospital)
- Measure Days (Hospital's Excess Days)
- Compare* (Hospital's performance category)

***Note:** The national compare values and confidence intervals are currently suppressed and display 'Not Available' for these measures and will continue to be suppressed until the July 2027 Public Reporting Preview Report and release. Individual hospital measure rates were not impacted.

The national averages include data from VHA hospitals. HSRs are available to hospitals via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for the EDAC measures.

+Payment
Medicare Spending per Beneficiary (MSPB-1)

Medicare Spending per Beneficiary (MSPB)

The MSPB measure assesses Medicare Part A and Part B payments for services provided to a Medicare beneficiary during an episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge.

The payments included in this measure are price-standardized and risk-adjusted. Price standardization removes sources of variation that are due to geographic payment differences, such as wage index, geographic practice cost differences, indirect medical education, or disproportionate share hospital payments. Risk adjustment accounts for variation due to patient age and health status.

By measuring cost of care through this measure, CMS hopes to increase the transparency of care for consumers and recognize hospitals for the provision of high-quality care.

The results for the MSPB measure will be updated annually in the January public reporting release on the Compare tool on Medicare.gov. Hospitals are not required to submit data for the measure because CMS calculates the measure from claims and enrollment data.

HSRs are available to hospitals via the HQR system and provide the main components used to calculate and compare MSPB Hospital measure results. This includes average payment-standardized, risk-adjusted MSPB Hospital Amounts at the hospital, state, and national level.

+Patient-Reported Outcome
Patient-Reported Outcome-Based Performance Measure (PRO-PM) THA/TKA PRO-PM

THA/TKA Patient-Reported Outcome-Based Performance Measure

CMS adopted the THA/TKA Patient-Reported Outcome-Based Performance Measure (PRO-PM) for use in the Hospital IQR Program beginning with FY 2026 voluntary reporting, which was associated with procedures from January 1, 2023, through June 30, 2023. The purpose of voluntary reporting is to familiarize hospitals with the measure in advance of public reporting and payment determination. The measure will become mandatory in FY 2028 payment determination, which is associated with procedures from July 1, 2024, through June 30, 2025.

The goal of the hospital-level THA/TKA PRO-PM is to capture the patient's self-assessment of their pain and function and measure their improvement following their THA/TKA. The THA/TKA PRO-PM utilizes the patient voice in the measure outcome and directly captures the results of their THA/TKA.

During the voluntary period, assessment response rate for hip/knee replacement patients preview report will display the following:

- Completed surveys
- Eligible patients
- Response rate
- Facility Score
- National Score

Providers who have voluntarily submitted surveys will be listed on the Compare tool on Medicare.gov as participating and hospitals with at least 25 cases will also have their response rate displayed. This measure is updated annually in the July public reporting release.

Outpatient Hospital Measures

Accordions

+Survey of Patient Experience – Outpatient Surgery and Procedures
Survey of Patient Experience-Outpatient Surgery and Procedures (OAS CAHPS)

The OAS CAHPS survey data display as aggregate results. Each hospital's aggregate results are compared to state and national averages. The preview data also includes each hospital's total number of completed surveys and survey response rate for the reporting period. OAS CAHPS data are updated with each quarterly public reporting release. OAS CAHPS linear mean scores are provided for each of the composite measures and global items. The scores are available in the downloadable database on the Data Catalog at data.cms.gov.

Responses are displayed for the following:

- OP-37a Facilities and Staff, includes questions 3-8
- OP-37b Communications About Your Procedure, includes questions 1, 2, 9-12
- OP-37c Preparing for Discharge and Recovery, includes question 13-22
- OP-37d Patients' Rating of the Facility
- OP-37e Patients Recommending the Facility

State and national unweighted average rates for each OAS CAHPS measure are calculated based on all available OAS CAHPS data.

More information on OAS CAHPS is available at: https://oascahps.org

+Timely and Effective Care
Emergency Department (OP-18a, OP-18b, OP-18c, OP-18d, OP-22, OP-23)
Cardiac Care (OP-40)
Cataract Care (OP-31)
Colonoscopy (OP-29)

Emergency Department Measures

OP-18a, OP-18b, OP-18c, OP-18d, OP-22, OP-23

The Emergency Department (ED) Measures contain up to four quarters of data. They are calculated from all payer patient encounter data manually extracted from clinical documentation and submitted for a hospital. For OP-23, denominators greater than 0 and less than 11 will display on the Preview UI but not Care Compare on Medicare.gov.

OP-22 data are entered annually into a web-based tool in the HQR system by the hospital.

ED measures include:

- OP-18a: Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate
- OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients– Excludes Psychiatric/Mental Health Patients and Transfer Patients

- OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients
- OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED patients – Transfer Patients
- OP-22: Left without Being Seen
- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival.

These measures display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

Emergency Department Volume (EDV) states the total number of patients that present to the ED. It is derived from the denominator of the measure OP-22: Left without Being Seen.

Category assignments are:

- Very high: values of 60,000 or greater patients per year
- High: values ranging from 40,000 to 59,999 patients per year
- Medium: values ranging from 20,000 to 39,999 patients per year
- Low: values less than or equal to 19,999 patients per year

The **state performance rate** is derived for each measure by summing the numerators for all cases in the state that are publicly reported, then dividing by the sum of the denominators in the state that are publicly reported. Median times are identified using all cases in the state that are publicly reported.

The **national performance rate** is derived for each measure by summing the numerators for all cases in the nation, then dividing by the sum of the denominators in the nation. Median times are identified using all cases in the nation that are publicly reported.

The **90th percentile** is calculated for each measure using the median for each eligible hospital and identifying the top 10 percent of hospitals.

Cardiac Care Measure

OP-40

The ST-Segment Elevation Myocardial Infarction (STEMI) eCQM contains up to four quarters of data, displayed as an aggregate rate and based on data submitted via EHR. The data will be updated annually based on data submitted by the eCQM submission deadline. Denominators greater than 0 and less than 25 will display on the Preview UI but not in the Data Catalog on data.cms.gov.

The facility-level data displayed on the preview report will only be included in the Timely and Effective Care downloadable databases on the Data Catalog on data.cms.gov.

The STEMI eCQM displays:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rate** is derived by summing the numerators for all cases in the state that are publicly reported, then dividing by the sum of the denominators in the state that are publicly reported. The state performance rates displayed on the preview report are for informational purposes. CMS will not publicly report the state performance rate at this time.

The **national performance rate** is derived by summing the numerators for all reported cases in the nation, then dividing by the sum of the denominators in the nation. The national performance rate displayed on the preview report is for informational purposes. CMS will not publicly report the national performance rate at this time.

The **90th percentile** is calculated using the unweighted average or median for each eligible hospital and identifying the top 10% of hospitals. The top 10% performance rate displayed on the preview report is for informational purposes. CMS will not publicly report the top 10% performance rate at this time.

Cataract Measure

OP-31(voluntary)

The Cataracts-Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery Measure displays:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The performance rates for the Cataract Visual Function Measure are calculated using publicly reported data from the Clinical Warehouse. Denominators greater than 0 and less than 11 will display on the Preview UI but not the Compare tool on Medicare.gov.

The **facility performance rate** is derived by summing the numerators for all cases that are publicly reported by the facility, then dividing by the sum of the denominators in the facility that are publicly reported.

The **state performance rate** is derived by summing the numerators for all cases in the state that are publicly reported, then dividing by the sum of the denominators in the state that are publicly reported.

The **national performance rate** is derived by summing the numerators for all cases that are publicly reported in the nation, then dividing by the sum of the denominators in the nation that are publicly reported.

The **90th percentile** is calculated using the un-weighted average for each eligible hospital and identifying the top 10 percent of hospitals.

Colonoscopy Measure

OP-29

The Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Measure displays:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The performance rates for the Colonoscopy Measure are calculated using publicly reported data from the Clinical Warehouse. The state and national rates include data from the Department of Defense (DoD). Denominators greater than 0 and less than 11 will display on the Preview UI but not the Compare tool on Medicare.gov.

The **facility performance rate** is derived by summing the numerators for all cases that are publicly reported by the facility, then dividing by the sum of the denominators in the facility that are publicly reported.

The **state performance rate** is derived by summing the numerators for all cases that are publicly reported in the state, then dividing by the sum of the denominators in the state that are publicly reported.

The **national performance rate** is derived by summing the numerators for all cases that are publicly reported in the nation, then dividing by the sum of the denominators in the nation that are publicly reported.

The **90th percentile** is calculated using the un-weighted average for each eligible hospital and identifying the top 10 percent of hospitals.

+ Unplanned Hospital Visit
Procedure Specific Outcomes (OP-32, OP-35 ADM, OP-35 ED, OP-36)

Procedure Specific Outcomes Measures

OP-32, OP-35 ADM, OP-35 ED, OP-36

Procedure Specific Outcomes Measures will be updated annually during the January public reporting release. Hospitals are not required to submit any data because CMS calculates the measures from claims and enrollment data.

Hospitals with fewer than 25 eligible cases for the measure are assigned to a separate category described as, “The number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing.” They are included in the measure calculation, but they will not be reported on the Compare tool on Medicare.gov.

These measures display:

- Eligible Cases

- Facility Rate/Ratio
- National Rate/Ratio
- National Compare

OP-32, Facility 7-day Risk-Standardized Hospital Visit After Outpatient Colonoscopy Measure calculates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare Fee-For-Service (FFS) patients aged 65 years and older.

OP-35, Admissions (ADM) and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy-Risk Standardized Admission & ED Rates calculates two mutually exclusive outcomes:

- One or more inpatient admissions for anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis within 30 days of chemotherapy treatment.
- One or more ED visits for any of the same 10 diagnoses within 30 days of chemotherapy treatment.

OP-36, Hospital Visits After Hospital Outpatient Surgery, calculates a facility-specific risk-standardized hospital visit ratio within seven days of hospital outpatient surgery. The measure compares results to a value of 1 rather than a national average. The measure is calculated using one year of data.

HSRs are available to hospitals via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for the outcome measures.

+ Use of Medical Imaging
Imaging Efficiency (OP-10, OP-39)

Imaging Efficiency Measures

OP-10, OP-39

The Outpatient Imaging Efficiency (OIE) measures are calculated by CMS using Medicare FFS paid claims. The data are updated annually with the July release of the Compare tool on Medicare.gov. Some rates or ratios for hospitals will not be displayed due to minimum case counts not being met. Facilities must have at least 31 cases to qualify for public reporting; this number can vary from 31 to 67, depending on a facility's performance rate.

These measures display:

- Number of Patients/Scans
- Facility Rate
- State Rate
- National Rate

OP-10, Abdomen CT–Use of Contrast Material measure calculates the percentage of CT abdomen or abdominopelvic studies that are performed with and without contrast. The measure is calculated based on a 12-month window of claims data.

OP-39, Breast Cancer Screening Recall Rates measure calculates the percentage of mammography and DBT screening studies that are followed by diagnostic mammography, DBT, ultrasound, or MRI of the breast in an outpatient or office setting within 45 days of the index study.

The **state and national performance rates** for each Use of Medical Imaging measure are calculated based on Medicare claims data, regardless of whether hospitals elected to opt out of publicly reporting their data.

HSRs are available to hospitals via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for the OIE measures.

Inpatient Psychiatric Facility (IPF) Measures

Accordions

+ Unplanned Hospital Visits
Inpatient Psychiatric Facility Readmission (READM-30-IPF)

Inpatient Psychiatric Facility Readmission

READM-30-IPF

The Inpatient Psychiatric Facility Readmission section includes READM-30-IPF (Rate of readmission after IPF discharge). Facilities are not required to submit these data because CMS calculates the measures from claims and enrollment data using 24 months of data. Facilities with fewer than 25 eligible cases for the readmission measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the facility is performing" and are included in the measure calculation but will not be reported on the Compare tool on Medicare.gov.

The measure will display the following data:

- Eligible Discharges
- Facility Rate/Value
- National Rate/Value
- National Compare

The facility's 95% Interval Estimates are provided in a modal that can be viewed by selecting the data value for the measure in the Facility Rate/Value column.

State rates do not display for the readmission measures. However, the national observed result and the number of facilities in the state and the nation whose performance was categorized as Better than, Same as, Worse than the National Rate/Value or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the National Rate/Value column in the accordion.

IPF Specific Reports (ISRs) are available to facilities via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for this readmission measure.

+ Follow-Up Care
Transition Record (TR1)
Follow up After Psychiatric Hospitalization (FAPH-30, FAPH-7)
Medication Continuation Following Inpatient Psychiatric Discharge (MedCont)

Transition Record

TR1

The Transition Record measure displays data calculated from 12 months of facility submitted data.

The TR-1 measure will display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rate** is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rate** is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentile** is calculated for each measure using the un-weighted average or median for each eligible facility and identifying the top 10% of facility.

Follow-Up After Psychiatric Hospitalization (FAPH)

The Follow-Up After Psychiatric Hospitalization section contains the following measures:

- FAPH-30: Follow-Up after Psychiatric Hospitalization 30-Days
- FAPH-7: Follow-Up after Psychiatric Hospitalization 7-Days

These measures display data calculated from 12 months of claims and enrollment data. Facilities are not required to submit these data.

The measures display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rate** is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rate** is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentile** is calculated for each measure using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

Medication Continuation Following Inpatient Psychiatric Discharge

MedCont

The Medication Continuation Following Inpatient Psychiatric Discharge section contains the MedCont (Medication Continuation Following Inpatient Psychiatric Discharge) measure. The measure displays data calculated from 12 months of claims and enrollment data. Facilities are not required to submit these data.

The measures display the following data:

- Facility Rate
- Number of Patients

- State Rate
- National Rate
- Top 10%

The **state performance rate** is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rate** is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentile** is calculated for each measure using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

+ Substance Use Treatment
Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (TOB-3, TOB-3a)

Substance Use

SUB-2, SUB-2a, SUB-3, SUB-3a

The **Substance Use** measures display data calculated from 12 months of facility submitted data.

This section contains the following measures:

- SUB-2: Alcohol Use Brief Intervention Provided or Offered
- SUB-2a: Alcohol Use Brief Intervention
- SUB-3: Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge
- SUB-3a: Alcohol and other Drug Use Disorder Treatment Provided at Discharge

Tobacco Use

TOB-3, TOB-3a

The **Tobacco Use** measures display data calculated from 12 months of facility submitted data.

This section contains the following measures:

- TOB-3: Tobacco Use Treatment Provided or Offered at Discharge
- TOB-3a: Tobacco Use Treatment at Discharge

Measure Details for the Substance Use and Tobacco Use Measures

These measures display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rates** are derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rates** are derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentiles** are calculated for each measure using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

+ Patient Safety

Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3)

HBIPS Measures

HBIPS-2, HBIPS-3

The HBIPS measures display data calculated from 12 months of facility submitted data.

This section includes the following measures:

- HBIPS-2: Hours of physical restraint use
- HBIPS-3: Hours of seclusion use

The measures display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%

The **state performance rates** are derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rates** are derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentiles** are calculated for each measure using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

+ Preventative Care and Screening

Screening (SMD)

Immunization (IMM-2)

Screening

SMD

The screening measure section contains the Screening for Metabolic Disorders (SMD) measure and displays data calculated from 12 months of facility submitted data.

The measures display the following data:

- Facility Rate
- Number of Patients
- State Rate

- National Rate
- Top 10%

The **state performance rates** are derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rates** are derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentiles** are calculated using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

Immunization

IMM-2

The aggregate rate for the IMM-2 measure includes data collected only during the influenza season quarters. Data displayed are for the 2025/2026 influenza season, Q4 2025–Q1 2026.

The **state performance rate** is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state.

The **national performance rate** is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation.

The **90th percentiles** are calculated using the un-weighted average or median for each eligible facility and identifying the top 10% of facilities.

Prospective Payment System (PPS)-exempt Cancer Hospital (PCH) Measures

Accordions

+Survey of Patients' Experience
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Survey of Patient Experience-Hospital Inpatient

The HCAHPS Survey data display aggregate results. Each hospital's aggregate results are compared to state and national averages. The preview data also includes each hospital's total number of completed surveys and survey response rate for the reporting period. The HCAHPS measures are updated quarterly with each public reporting release.

HCAHPS Star Ratings are based on the quarters of survey data included in the preview. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 11 HCAHPS measures and the HCAHPS Summary Star Rating, which is a single summary statistic of all the HCAHPS Star Ratings. The Preview dataset also contains 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: https://hcahpsonline.org/en/hcahps-star-ratings/.

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

- HCAHPS Star Ratings are provided for each of the seven composite measures, two individual items, and two global items.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 11 HCAHPS measures, plus the HCAHPS Summary Star Rating.

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the seven composite measures, two individual items, and two global items. The scores are available in the downloadable database on the Provider Data Catalog at data.cms.gov.

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.

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.

+Patient Engagement/Experience of Care
Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42)

Documentation of Goals of Care Discussions Among Cancer Patients

PCH-42

Calculates the percent of cancer patients who died during the reporting period and had patients' goals of care documented prior to death. The data is updated annually in July.

The PCH-42 measure displays the following data:

- Denominator
- Facility Rate
- National Rate

+Timely and Effective Care
Healthcare Personnel Vaccination (PCH-28)
Patient Safety Structural Measure (PSSM)

Influenza Vaccination Coverage Among Healthcare Personnel

PCH-28

Influenza Vaccination Coverage Among HCP (PCH-28) includes the number of HCP 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 HCP contributing to successful vaccination adherence divided by the total number of HCP who physically worked in the facility for at least one working day between October 1 through March 31 per the CDC's NHSN protocol.

Patient Safety Structural Measure (PSSM)

Data display a score of 0–5 based on hospital attestation on how hospitals demonstrated having a structure and culture that prioritizes patient safety.

The data display:

- Total Hospital Score
- The number and percentage of hospitals in the state and nation that received each of the possible scores.

+Complications & Deaths
Infections (PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, PCH-27)
Surgical Treatment Complications (PCH-37)

Infections

PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, PCH-27

Hospitals submit Healthcare-Associated Infections (HAI) data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on Data Catalog on data.cms.gov. These measures are updated with each of the quarterly public reporting releases.

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

- PCH-4 Central Line-associated Bloodstream Infection (CLABSI)
- PCH-5 Catheter-associated Urinary Tract Infection (CAUTI)
- PCH-6 Surgical Site Infection: Colon
- PCH-7 Surgical Site Infection: Abdominal Hysterectomy
- PCH-26 *Clostridioides difficile* Infection (CDI)
- PCH-27 Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia

PCH-4 — Central Line-associated Bloodstream Infection (CLABSI)

The CLABSI measure for the PCH Quality Reporting Program includes oncology intensive care unit (ICU), ward, and step-down unit patients for events identified within the displayed time frame.

PCH-5 — Catheter-associated Urinary Tract Infection (CAUTI)

The CAUTI measure for the PCH Quality Reporting Program includes oncology ICU, ward, and step-down unit patients for events identified within the displayed time frame.

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 — *Clostridioides 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 information is displayed in the following columns:

- Predicted
- Reported
- Days/Procedure

- Facility Ratio
- National Ratio
- National Compare

Predicted

The 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 2022 (resulting in the updated Standardized Infection Ratio [SIR] baseline described above) and is risk adjusted for the hospital based on several factors. The predicted number of infections is used by NHSN as the denominator to calculate the hospital's SIR.

Reported

The hospital's **reported number of infections** is the observed number of infections reported by the hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate the 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 the Data Catalog on data.cms.gov.

Days/Procedure

PCH-4 (CLABSI): The number of central line days in hospital locations in scope (oncology ICU, ward, and step-down unit) for quality reporting.

PCH-5 (CAUTI): The number of urinary catheter days in hospital locations in scope (oncology ICU, ward, and step-down unit) for quality reporting.

PCH-6 (SSI-Colon): The procedure count field on this preview and in the Provider Data Catalog on data.cms.gov 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/2022rebaseline/sir-guide.pdf

PCH-7 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on the Provider Data Catalog on data.cms.gov 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/2022rebaseline/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 the hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/2022rebaseline/sir-guide.pdf

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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 the 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 the 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 the Data Catalog on data.cms.gov.

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 the Data Catalog on data.cms.gov. to avoid confusion with the National SIR Benchmark used to compare hospital performance.

National Comparison

The hospital's performance phrase is determined by comparing the 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 the hospital's SIR has an upper limit that is less than the National Benchmark of one
- **Same** (No Different than National Benchmark): Displays if the 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 the hospital's SIR has a lower limit that is greater than the National Benchmark of one.

Surgical Treatment Complications

PCH-37

The surgical treatment complications section of the Preview UI displays PCH-37 **Surgical Treatment Complications for Localized Prostate Cancer.**

The Surgical Treatment Complications for Localized Prostate Cancer measure provides facilities with information to improve the quality of care delivered to patients who underwent prostate cancer surgery. The measure calculates a score (between 0 and 100) based on the number of hospital visits for incontinence and/or erectile dysfunction prostate cancer patients had in the year before versus the year after the prostate cancer surgery.

The measure displays:

- Eligible Patients
- Facility Score
- National Score

+Unplanned Hospital Visits
Procedure Specific Outcomes (PCH-30, PCH-31) Readmission Measures (PCH-36)

Procedure Specific Outcomes

PCH-30, PCH-31

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

Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

Hospitals with fewer than 25 eligible cases for these measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing."

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

Additional details, including the 95% Interval Estimates, can be found by selecting the data next to the asterisk in the Facility Rate/Value column.

The national observed result and the number of hospitals in the nation whose performance was categorized as Better, No Different, or Worse than the National Rate/Value can be found by selecting the data next to the asterisk in the National Rate/Value column in the accordion.

Readmission Measures

PCH-36

The readmission outcome measure section of the Preview UI includes PCH-36 30-Day Unplanned Readmission for Cancer Patients. The Preview UI displays four quarters of data. The data are updated annually in October.

Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

Hospitals with fewer than 25 eligible cases for these measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing."

Each measure displays the following:

- Eligible Discharges
- Facility Rate
- National Rate
- National Compare

Additional details, including the 95% Interval Estimates, can be found by selecting the data next to the asterisk in the Facility Rate/Value column.

The national observed result and the number of hospitals in the nation whose performance was categorized as Better, No Different, or Worse than the National Rate/Value can be found by selecting the data next to the asterisk in the National Rate/Value column in the accordion.

+Palliative Care
End-of-Life (EOL) Measures (PCH-32, PCH-33, PCH-34, PCH-35)

End-of-Life (EOL) Measures

PCH-32, PCH-33, PCH-34, PCH-35

These are a claims-based measures, using all unique Medicare patients for the time-period specified as identified in the Medicare Fee for Service (FFS). Data is updated annually with the July release.

The Palliative Care section of the UI includes the following Measures:

- **PCH-32** Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
- **PCH-33** Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life
- **PCH-34** Proportion of Patients Who Died from Cancer Not Admitted to Hospice
- **PCH-35** Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days

Each measure displays the following:

- Denominator
- Facility Rate
- National Rate

The **national performance rate** is derived by summing the numerators for all PCH designated provider's cases in the nation divided by the sum of the denominators in the nation.

Rural Emergency Hospital (REH) Measures

Accordions

+Timely and Effective Care
Emergency Department (OP-18a, OP-18b, OP-18c, OP-18d)

Emergency Department Measures

OP-18a, OP-18b, OP-18c, OP-18d

Measures OP-18a, OP-18b, OP-18c, OP-18d, contain up to four quarters of data. These measures are calculated from all payer patient encounter data manually extracted from clinical documentation and submitted for an REH.

ED measures include:

- OP-18a: Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate
- OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients– Excludes Psychiatric/Mental Health Patients and Transfer Patients
- OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Psychiatric/Mental Health Patients
- OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED patients – Transfer Patients

These measures display the following data:

- Facility Rate
- Number of Patients
- National Rate
- Top 10%

The **national performance rate** is derived for each measure by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation. Median times are identified using all cases in the nation that are publicly reported.

The **90th percentile** is calculated for each measure using the median for each eligible hospital and identifying the top 10 percent of hospitals.

+ Unplanned Hospital Visit
Procedure Specific Outcomes (OP-36)

Procedure Specific Outcomes Measures

OP-36, Hospital Visits After Hospital Outpatient Surgery, calculates a facility-specific risk-standardized hospital visit ratio within seven days of hospital outpatient surgery. The measure compares results to a value of 1 rather than a national average and is calculated using two years of data.

OP-36 will be updated annually during the January public reporting release. REHs are not required to submit any data because CMS calculates the measures from claims and enrollment data.

REHs with fewer than 25 eligible cases for the measure are assigned to a separate category described as, "The number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing." They are included in the measure calculation, but they will not be reported on the Compare tool on Medicare.gov.

These measures display:

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

HSRs are available to REHs via the HQR system and provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for the outcome measures.

+ Use of Medical Imaging
Imaging Efficiency (OP-10)

Imaging Efficiency Measures

OP-10, Abdomen CT–Use of Contrast Material measure calculates the percentage of CT abdomen or abdominopelvic studies that are performed with and without contrast. The measure is calculated based on a 12-month window of claims data

OP-10 is calculated by CMS using Medicare FFS paid claims. The data are updated annually with the January release of the Compare tool on Medicare.gov. Some rates or ratios for REHs will not be displayed due to minimum case counts not being met.

Star Rating Tab

The Star Rating tab displays the Overall Hospital Quality Star Ratings (Overall Star Ratings), facility details (hospital characteristics), summary score, and standardized measure group scores refreshed in the April 2026 release. The displays are based on publicly reported data released in October 2025 on the Compare tool on Medicare.gov. Each group accordion displays the performance for the group and expands to provide additional information.



Additional information at the bottom of the Star Ratings tab includes a link to additional information and resources on the QualityNet Overall Hospital Quality Star Ratings web page.

Overall Hospital Quality Star Rating Hospital-Specific Reports (HSRs)

The Overall Hospital Quality Star Rating HSR contains hospital-specific Overall Star Rating and national results, hospital-specific measure group score results and weights, hospital-specific measure score results, and hospital-specific peer grouping for the reporting period. Hospitals are encouraged to review their Overall Hospital Quality Star Rating HSRs along with the Hospital Inpatient and Outpatient Quality Reporting Program Preview data for star rating calculations. These HSRs are provided when the Overall Hospital Quality Star Rating is recalculated annually.

Promoting Interoperability Program Tab

Select the **Promoting Interoperability Program** tab at the top of the preview UI page to view the program specific information.

The Medicare Promoting Interoperability Program information is updated annually with the October release.

Program Information displays:

- EHR Certification Number (CEHRT ID)
- Meets the Criteria for Medicare Promoting Interoperability

Information regarding eCQM data is displayed in the **Inpatient Hospital Measure** section of this Help Guide. To view the eCQM data on the preview UI, select the **Measure Data** tab at the top of the preview UI.

The **Timely and Effective Care** accordion contains:

- Safe Use of Opioids: Safe Use of Opioids—Concurrent Prescribing
- VTE-1: Venous Thromboembolism Prophylaxis
- VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
- STK-02: Discharged on Antithrombotic Therapy
- STK-03: Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-05: Antithrombotic Therapy by End of Hospital Day 2
- HH-AKI: Hospital Harm-Acute Kidney Injury
- HH-HYPO: Hospital Harm-Severe Hypoglycemia
- HH-HYPER: Hospital Harm-Severe Hyperglycemia
- HH-ORAE: Hospital Harm-Opioid Related Adverse Events
- HH-PI: Hospital Harm-Pressure Injury
- IP-ExRad: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults
- MCS: Malnutrition Care Score

Note: Safe Use of Opioids—Concurrent Prescribing measure will display facility, state, and national level data on both the data catalog on data.cms.gov and the Compare tool on Medicare.gov.

The **Maternal Health Measure** accordion contains**:** PC-02, PC-07a, and PC-07b

PC-02, PC-07a and PC-07b measures will display facility, state and national level data in the Maternal Health files on the data catalog on data.cms.gov and in the Maternal Health section on the Compare tool on Medicare.gov.

The Data Catalog on data.cms.gov has data reported for the Medicare Promoting Interoperability Program within the Promoting Interoperability dataset.

Additional information regarding the Medicare Promoting Interoperability Program can be found here: https://qualitynet.cms.gov/inpatient/PI

Withholding Data from Public Reporting

Hospitals participating in the Hospital IQR Program agree to have data publicly reported on the Compare tool on Medicare.gov and the Data Catalog on data.cms.gov

Hospitals voluntarily submitting data to the Hospital IQR Program with an Optional Public Reporting Notice of Participation have the option to withhold data from being publicly reported on those sites. The option to request withholding of data from being publicly reported is only available during the 30-day preview period.

Withholding Overview

To withhold publication of data, the hospital must complete and fax or email a **Request Form for Withholding/Footnoting Data for Public Reporting** on or before the last day of the preview period to the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Contractor.

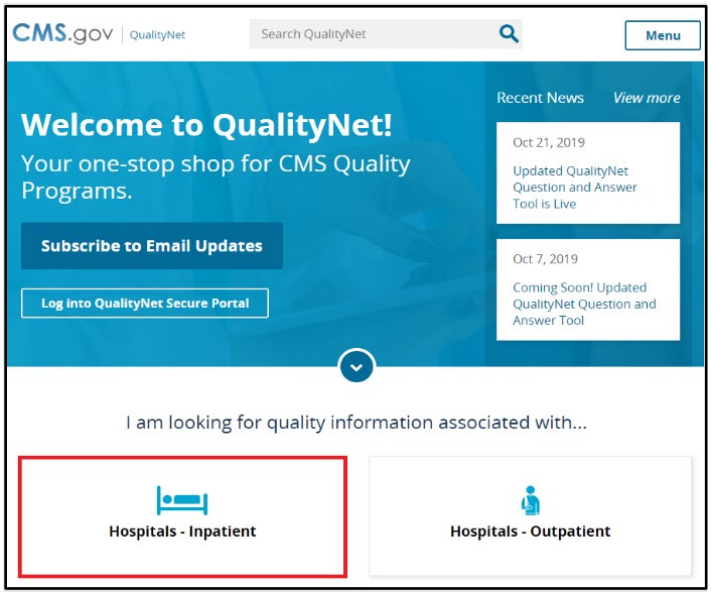
Hospitals that do not have an appropriate Notice of Participation, or pledge, display only the CCN, hospital name and the following message: "You do not have an Inpatient Notice of Participation to publicly report data for the Preview period."

Note: If you received this message in error, contact the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Contractor prior to the last day of the preview period.

Questions regarding the Hospital IQR Program may be directed to the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Contractor through the QualityNet Question and Answer Tool, or by calling, toll-free, (844) 472-4477 or (866) 800-8765 weekdays from 9 a.m. to 5 p.m. Eastern Time.

Procedure to Withhold Data

1. Access the public website for QualityNet at https://qualitynet.cms.gov/.
2. Click on the **Hospitals - Inpatient** card.



3. Select the **Public Reporting** tab.



4. Select **Learn more** under Care Compare Public Reporting.



5. Select the **Resources** tab.



6. Select the **Request for Withholding Data from Public Reporting** form. Complete the form and fax or email to the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Contractor prior to the last day of the preview period at secure fax (877) 789-4443 or email QRFormsSubmission@hsag.com.

Any forms received after the preview period **will not have the requested measures withheld** for that Compare tool on Medicare.gov.
or Data Catalog on data.cms.gov release.

Hospitals voluntarily submitting data to the Hospital IQR Program with Optional Public Reporting Notice of Participation have an option to withhold data from public reporting on the Compare tool on Medicare.gov and Data Catalog on data.cms.gov. The option to request withholding of data from the Compare tool on Medicare.gov and Data Catalog on data.cms.gov website is only available during the 30-day preview period.

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient Experience-Hospital Inpatient	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Restfulness of Hospital Environment Care Coordination Responsiveness of Hospital Staff Communication About Medicines Discharge Information Cleanliness of Hospital Environment Information About Symptoms Overall Hospital Rating Willingness to Recommend this Hospital
Patient Engagement/ Experience of Care	Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42)
Survey of Patient Experience – Outpatient and Ambulatory Surgery	Outpatient and Ambulatory Surgery Consumer Assessment (OAS CAHPS) Facilities and Staff Communication About Your Procedure Preparing for Discharge and Recovery Patients' Rating of the Facility Patients Recommending the Facility
Timely and Effective Care	Sepsis (SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR) Emergency Department Care (OP-18a, OP-18b, OP-18c, OP-18d, OP-22, OP-23) Healthcare Personnel Vaccination (IMM-3, PCH-28) Cardiac Care (OP-40) Cataract Care (OP-31) Colonoscopy (OP-29) Opioid Use (Safe Use of Opioids—Concurrent Prescribing) Venous Thromboembolism (VTE-1, VTE-2) Stroke Care (STK-02, STK-03, STK-05) Hospital Harm (HH-AKI, HH-HYPO, HH-HYPER, HH-ORAE, HH-PI) Excessive Radiation (IP-ExRad) Malnutrition Care Score (MCS) Age Friendly Hospital (AFH) Patient Safety Structural Measure (PSSM)

Measure Accordion	Measure IDs Included
Maternal Health	Maternal Morbidity (SM-7) Perinatal Care (PC-02, PC-07a, PC-07b)
Complications & Deaths	30-Day Death Rates (Hybrid HWM, MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG) CMS Patient Safety Measures (PSI 03, PSI 06, PSI 08, PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, PSI 15, PSI 90, ISCMR) Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6, PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, PCH-27) Surgical Complications (COMP-HIP-KNEE) Surgical Treatment Complications (PCH-37)
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 (Hybrid HWR) 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)
Payment	Medicare Spending per Beneficiary (MSPB-1)
Follow-Up Care	Transition Record (TR1, TR2) Follow-Up After Psychiatric Hospitalization (FAPH-7, FAPH-30) Medication Continuation Following Inpatient Psychiatric Discharge (MedCont)
Substance Use Treatment	Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (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-10, OP-39)
Palliative Care	End-of-Life (EOL) Measures (PCH-32, PCH-33, PCH-34, PCH-35)
Patient Reported Outcome	THA/TKA Patient-Reported Outcome-Based Performance Measure (voluntary) (THA/TKA PRO-PM)

Footnote Table

Number	Description	Application
1	The number of cases/ patients is too few to report	This footnote is applied: • When the number of cases/patients doesn't meet the required minimum amount for public reporting; • When the number of cases/patients is too small to reliably tell how well a healthcare facility is performing; and/or • To protect personal health information.
2	Data submitted were based on a sample of cases/patients	Applied when any case submitted to the CMS Clinical Data Warehouse was sampled for a reported quarter for a topic; applied at the topic level (such as VTE)
3	Results are based on a shorter time period than required	This footnote indicates that the healthcare facility's results were based on data reported from less than the maximum possible time period used to collect data for a measure. View the data collection periods for more information. This footnote is applied: • When a healthcare facility elected not to submit data for a measure for one or more, but not all possible quarters; • When there was no data to submit for a measure for one or more, but not all possible quarters; and/or • When a healthcare facility did not successfully submit data for a measure for one or more, but not all possible quarters. Applied when a facility elected not to submit data, had no data to submit, or did not successfully submit data to the CMS Clinical Data Warehouse for a measure for one or more, but not all possible quarters.
4	Data suppressed by CMS for one or more quarters	The results for these measures were excluded for various reasons, like data inaccuracies.
5	Results are not available for this reporting period	This footnote is applied: • When a healthcare facility elected not to submit data for the entire reporting period; or • When a healthcare facility had no claims data for a particular measure; or • When a healthcare facility elected to suppress a measure from being publicly reported.

Number	Description	Application
6	Fewer than 100 patients completed the CAHPS survey (Use these scores with caution, as the number of surveys may be too low to reliably assess facility performance.)	Applied when the number of completed surveys the facility or its vendor provided to CMS is less than 100.
7	No cases met the criteria for this measure	Applied when a healthcare facility treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
8	The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero	For HAI measures: Applied when the lower limit of the confidence interval cannot be calculated.
9	No data are available from the state/territory for this reporting period.	This footnote is applied when: • Too few healthcare facilities in a state/territory had data available. OR • No data were reported for this state/territory.
10	Very few patients were eligible for the CAHPS 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 facility performance.)	This footnote is applied when the number of completed surveys the facility or its vendor provided to CMS is less than 50.
11	There were discrepancies in the data collection process	This footnote is applied when there have been deviations from data collection protocols. CMS is working to correct this situation. Applied when there have been deviations from HCAHPS data collection protocols.
12	This measure does not apply to this hospital for this reporting period	Applied to the measure when either the healthcare facility has a waiver, or the healthcare facility submitted to NHSN: • Zero Central Line Days • Zero Catheter Days • Zero Surgical Procedures

Number	Description	Application
13	Results cannot be calculated for this reporting period	Applied to emergency department measures when the average minutes cannot be calculated for a volume category. For HAI measures: Applied when the hospital's SIR cannot be calculated because: • The number of predicted infections is less than one. • The C. difficile prevalence rate is greater than the established threshold. Note: The number of predicted infections will not be calculated for those facilities with an outlier C. difficile prevalence rate. Applied when the provider was excluded from the measure calculation as a non-IPPS hospital. Applied to the value of care display if one of the two measures that assess value of care is unavailable.
14	The results for this state are combined with nearby states to protect confidentiality.	This footnote is applied when a state has fewer than 10 hospitals to protect confidentiality. Results are combined as follows: (1) the District of Columbia and Delaware are combined; (2) Alaska and Washington are combined; (3) North Dakota and South Dakota are combined; and (4) New Hampshire and Vermont are combined. Hospitals located in Maryland and U.S. territories are excluded from the measure calculation.
15	The number of cases/patients is too few to report a Star Rating.	This footnote is applied when the number of completed surveys the healthcare facility or its vendor provided to CMS is less than 100. To get CAHPS Star Ratings, healthcare facilities must have at least 100 completed CAHPS Surveys over a four-quarter period.
16	There are too few measures or measure groups reported to calculate an overall rating or measure group score.	This footnote is applied when a hospital: • Reported data for fewer than three measures in any measure group used to calculate overall ratings or • Reported data for fewer than three of the measure groups used to calculate ratings or • Did not report data for at least one outcomes measure group.

Number	Description	Application
17	This hospital's overall rating only includes data reported on inpatient services.	This footnote is applied when a hospital only reports data for inpatient hospital services.
22	Overall star ratings are not calculated for the Department of Defense (DoD) hospitals.	DoD hospitals are not included in the calculations of the overall star ratings.
23	The data are based on claims that the hospital or facility submitted to CMS, and/or encounter data that Medicare Advantage Organizations (MAOs) submitted to CMS. The hospital or facility has reported discrepancies in their claims and/or encounter data.	This footnote is applied when a hospital or facility alerts CMS of a possible issue with the claims or encounter data used to calculate results for this measure. Calculations are based on a "snapshot" of the administrative claims data and changes that hospitals or facilities make to their claims or encounter data after the snapshot are not reflected in the data. Issues with claims or encounter data include but are not limited to the use of incorrect billing codes or inaccurate dates of service.
25	State and national averages include VHA hospital data.	Applied to state and national data when VHA data are included in the calculation.
26	State and national averages include DoD hospital data.	Applied to state and national data when DoD data are included in the calculation.
27	The DoD TRICARE Inpatient Satisfaction Survey (TRISS) does not represent official HCAHPS results and are not included in state and national averages.	The DoD TRISS uses the same questions as the HCAHPS survey but is collected and analyzed independently.
28	The results are based on the hospital or facility's data submissions. CMS approved the hospital or facility's Extraordinary Circumstances Exception request suggesting that results may be impacted.	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.
29	This measure was calculated using partial performance period data due to a CMS-approved exception.	This footnote indicates that the hospital's results were based on data reported for less than the maximum possible time period used to collect data for a measure but not all quarters. This footnote is applied when CMS has approved an Extraordinary Circumstances Exception for one or more quarters of data used to calculate the results of this measure.

Resources

Questions should be directed to the subject matter experts listed below. For proper handling of inquiries, please reference the specific measure(s) and program(s) to which the questions relate. Do NOT submit patient-identifiable information (such as Date of Birth, Social Security Number, Medicare Beneficiary Identifier) to this tool.

Clinical Process, eCQM, HAI, and HCP Vaccination Measures

Contact the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Contract Team via the QualityNet Question and Answer Tool. For additional assistance, please contact the Center for Clinical Standards and Quality Service Center at https://cmsqualitysupport.servicenowservices.com/ccsq_support_central or (866) 288-8912.

For questions regarding the Medicare Promoting Interoperability Program, submit questions via the QualityNet Question and Answer Tool > Program: PI-Promoting Interoperability. Then, choose the specific topic.

CMS PSI Measures

For questions regarding the CMS PSIs, refer to CMS Patient Safety Indicators Frequently Asked Questions (FAQs) document on the Resources page on QualityNet, or contact the QualityNet Help Desk via the QualityNet Question and Answer Tool.

HCAHPS Measures

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

MSPB Measure

Submit MSPB inquiries by clicking on the Ask a Question tab in the QualityNet Question and Answer Tool> Program: Inpatient Claims-Based Measures > Topic: Medicare Spending Per Beneficiary > Measure Methodology

Outcome Measures Contacts

- Mortality Measures Implementation Team at QualityNet Question and Answer Tool > Program: Inpatient Claims-Based Measures > Mortality > Understanding Measure Methodology
- Readmission Measures Implementation Team at QualityNet Question and Answer Tool > Program: Inpatient Claims-Based Measures > Readmission > Understanding Measure Methodology
- THA/TKA Complication Measure Implementation Team at QualityNet Question and Answer Tool > Program: Inpatient Claims-Based Measures > Complication > Understanding Measure Methodology
- EDAC Measures Implementation Team at QualityNet Question and Answer Tool > Program: Inpatient Claims-Based Measures > Excess Days in Acute Care (EDAC) > Understanding Measure Methodology
- Hybrid Measures Implementation Team at QualityNet Question and Answer Tool > Program: IQR – Inpatient Quality Reporting > Hybrid Measures

TKA/TKA PRO-PM

Please contact the THA/TKA PRO-PM Implementation Team at QualityNet Question and Answer Tool > Program: IQR – Inpatient Quality Reporting > Topic: Hip/Knee PRO-PM

Overall Hospital Quality Star Ratings

Please contact the Overall Hospital Quality Star Ratings Team via the QualityNet Question and Answer Tool. Under Program please select: Overall Hospital Star Ratings and choose the specific Topic. This will get the inquiry directly to the Overall Star Ratings inbox.

Sepsis Measures

Please contact the Sepsis Team via the QualityNet Question and Answer Tool > Program: Inpatient – Measures & Data Element Abstraction.