Hospital Outpatient Public Reporting Preview Help Guide

Hospitals are the target audience for this publication.
The document scope is limited to instructions for hospitals to access and understand data provided on the public reporting user interface prior to publication on the Compare tool on Medicare.gov.

February 2025 Public Reporting Preview/April 2025 Public Reporting Release

CMS, in recognition of the impacts of the COVID-19 Public Health Emergency (PHE) on the ability to submit quality measure data, granted Extraordinary Circumstance Exceptions (ECEs) to individual hospitals that indicated the impact of the PHE continued beyond the already excluded data reflecting services provided January 1, 2020–June 30, 2020 (Quarter 1 and Quarter 2 2020).

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

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Overview

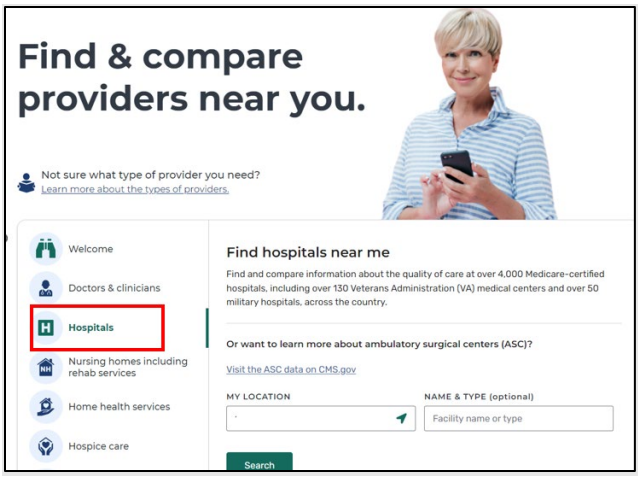
Compare Tool on Medicare.gov

CMS and the nation's hospitals 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/provider-data/.

The Compare tool on Medicare.gov displays hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals and IPFs. Most of the facilities that provide data are short-term acute care hospitals or IPFs that will receive a reduction to the annual update of their Medicare fee-for-service payment rate if they do not submit data or meet other requirements.

Navigating 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. Navigate to the data catalog at https://data.cms.gov/provider-data/. 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

Hospital Outpatient Quality Reporting (OQR) Program

The Hospital OQR Program is a pay-for-reporting program established under section 1833(t) of the Social Security Act, which affects the payment rate update applicable to payments for services furnished by hospitals in outpatient settings beginning in calendar year (CY) 2009.

Under the Hospital OQR Program, eligible **hospitals** are required to submit **data for standardized measures on the quality of hospital outpatient care** in the form, manner, and time as specified by

the Secretary. Eligible hospitals that do not participate or do not meet all program requirements will receive a 2.0-percentage point reduction of their annual payment update under the Outpatient Prospective Payment System (OPPS).

Preview Period

Prior to the public display of data on the Compare tool on Medicare.gov, hospitals are given the opportunity to preview their data during a 30-day preview period. The data anticipated for release can be accessed via the Hospital Quality Reporting system page at https://hqr.cms.gov/hqrng/login.

Public Reporting Preview User Interface (UI)

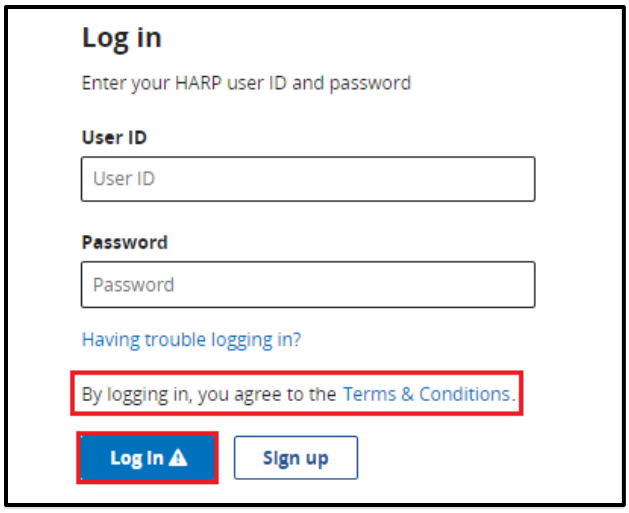
The Preview UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to the Compare tool on Medicare.gov.

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.

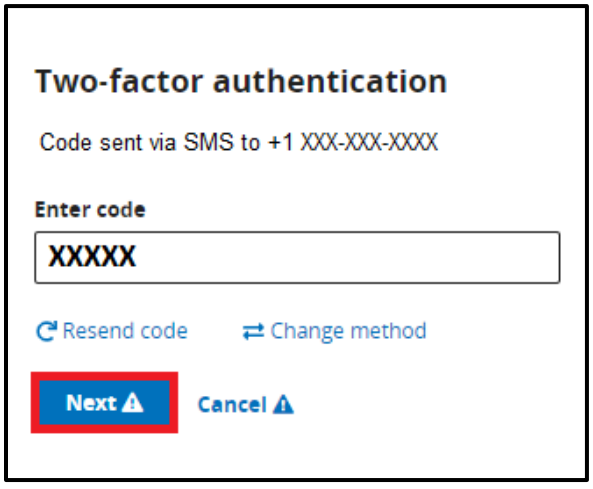
The HQR system no longer supports the use of Internet Explorer. To avoid technical issues when logging into the HQR system, please use either Google Chrome or Microsoft Edge.

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**.

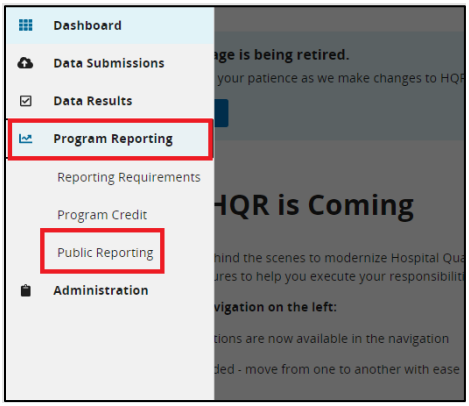


3. You will be directed to the **Two-Factor Authorization** page. Select the device you would like to verify via **Text** or **Email.** Select **Next**.
4. Once you receive the code via **Text** or **Email**, enter it. Select **Next**.



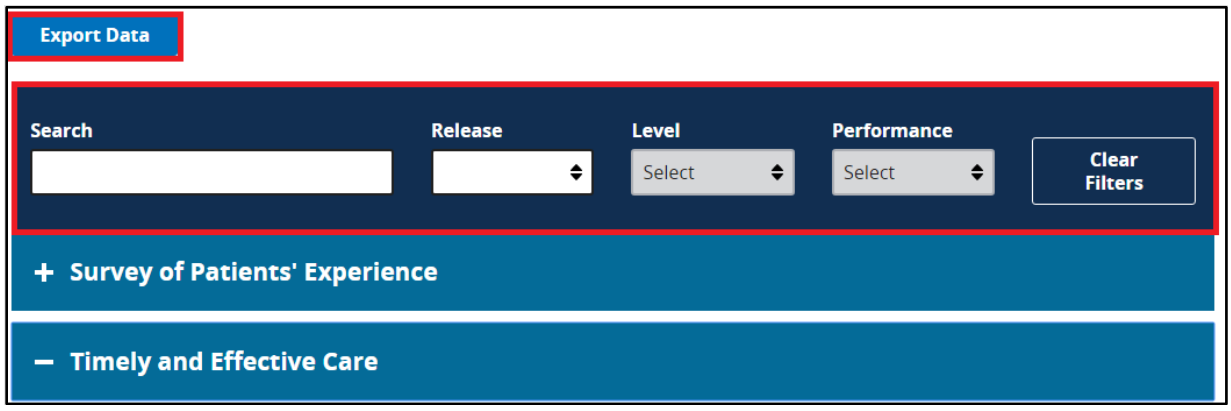
5. On the **HQR** system landing page, scroll to the bottom of the page and hover over the *Lock Menu* on the left side.

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**.

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



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

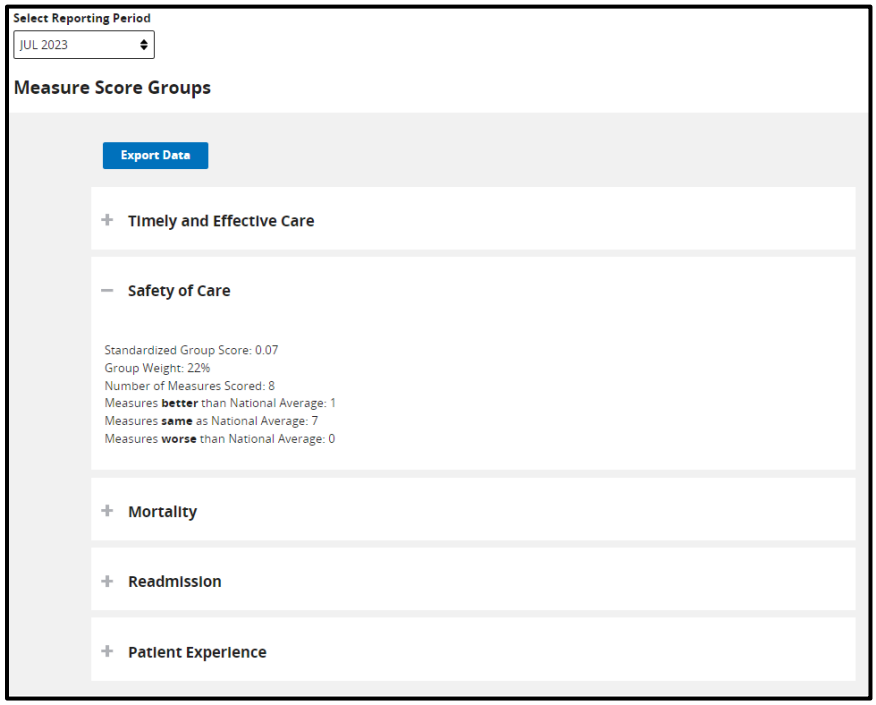
Search - Enter specific measures into this field and the table will dynamically filter for the appropriate content.

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

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

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 that were refreshed in the April 2025 release. The displays are based on publicly reported data released in October 2024 on the Compare tool on Medicare.gov. Each group accordion displays the performance for the group and expands to provide additional information.



The Mortality, Safety of Care and Readmission group score accordions expand to display the hospital's standardized group score, group weight, number of measures scored, and number of measures better, same or worse within the group. Patient Experience group score accordion expands to display the hospital's standardized group score and group weight only. Timely & Effective Care group score accordion expands to display the hospital's standardized group score, group weight and number of measures scored.

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.

The Overall Star Ratings summarize hospital quality data on the Compare tool on Medicare.gov. These ratings reflect measures across five aspects of quality: mortality, safety of care, readmission, patient experience, and timely and effective care.

The Overall Star Rating methodology is a scientifically rigorous and valid process to summarize the quality information available. The methodology was finalized in December 2020 in the calendar year (CY) 2021 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System final rule (CMS-1736-F). The Overall Star Rating supplements, rather than replaces, the information on the Compare tool on Medicare.gov.

For 2025, no changes were made to the Overall Star Rating in the calendar year 2024 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule.

The April 2025 Overall Star Rating results are displayed and will be maintained on the Compare tool on Medicare.gov until the next publishing of the Overall Star Rating in 2026.

Hospitals receive an Overall Star Rating (i.e., 1, 2, 3, 4, or 5 stars). The tab contains supplemental information for hospitals to better understand the Overall Star Rating calculations, which include: a summary score (i.e., the weighted average of a hospital's available group scores), the hospital's standardized group scores, the number of measures in the hospital's group score calculation, and the weighting of each group that contributed to the summary score.

Please refer to the Overall Hospital Quality Star Ratings methodology resources on the Overall Star Ratings Resources page at this link.

Overall Hospital Quality Star Rating Details

The April 2025 Overall Star Ratings are calculated using the measure data from the October 2024 release on the Compare tool on Medicare.gov and using the current 2021 methodology.

CMS has removed OP-2 and OP-3b, previously included in the Timely & Effective Care Measure Group, as both measures were retired from Care Compare on Medicare.gov in April 2024 and are no longer publicly reported.

For the first time, CMS has included the Safe Use of Opioids measure (Percentage of patients who were prescribed 2 or more opioids or an opioid and benzodiazepine concurrently at discharge) into the Overall Star Rating calculations. This measure is now part of the Timely and Effective Care Measure Group. It was first publicly reported as a mandatory measure on Care Compare on Medicare.gov in October 2024, making the measure eligible for inclusion.

CMS made the decision to use October 2024 measure data, although the measure reporting periods were impacted by measurement reporting exceptions announced by CMS.

For April 2025, only two measures, OP-32, and COMP/HIP/KNEE, have measure reporting periods that would have normally included 1Q and/or 2Q 2020. Please note, for April 2025, no measures include data from before 2020.

- **Your Hospital's Overall Star Rating** – 1, 2, 3, 4, or 5 stars. Hospitals that report at least three measures within three measure groups, one of which must specifically be Mortality or Safety of Care, are eligible for an Overall Star Rating. Not all hospitals report all measures. Therefore, some hospitals may not be eligible.
- **Your Hospital's Summary Score** – The weighted average of the hospital's group scores.
- **Measure Groups** − Hospital quality is represented by several dimensions, including clinical care processes, initiatives focused on care transitions, and patient experiences.
  The Overall Star Rating includes five groups:
  - Mortality
  - Safety of care
  - Readmission
  - Patient experience
  - Timely and Effective care
- **Number of Measures** – The number of measures used to calculate the hospital's group scores is based on the data the hospital reported.
- **Number of Measure compared to National Average** – The number of measures better, same or worse the national average within the measure group.

The Overall Star Rating aims to be as inclusive as possible of measures displayed on the Compare tool on Medicare.gov however, the following types of measures will not be incorporated in the Overall Star Rating:

- Measures suspended, retired, or delayed from public reporting.
- Measures with no more than 100 hospitals reporting performance publicly.
- Structural measures
- Non-directional measures (i.e., unclear whether a higher or lower score is better)

- Duplicative measures (e.g., individual measures that make up a composite measure that is already reported or measures that are identical to another measure)

The tables below include a full list of the measures included in each group that, if reported by the hospital, were used in calculating the Overall Star Rating for April 2025.

Mortality (N=7)

Measure	Description
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate
MORT-30-HF	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
PSI 04	Death among surgical inpatients with serious treatable complications

Safety of Care (N=8)

Measure	Description
HAI-1	Central Line-associated Bloodstream Infection (CLABSI)
HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)
HAI-3	Surgical Site Infection from colon surgery (SSI-colon)
HAI-4	Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)
HAI-5	Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia
HAI-6	Clostridium Difficile (C. difficile)
COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
PSI 90 Safety	Patient safety and adverse events composite

Readmission (N=11)

Measure	Description
READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate
READM-30-HIP-KNEE	Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)
READM-30-HOSP-WIDE	Hospital-Wide All-Cause Unplanned Readmission (HWR)
EDAC-30-PN	Excess Days in Acute Care (EDAC) after hospitalization for Pneumonia (PN)
EDAC-30-AMI	EDAC after hospitalization for Acute Myocardial Infarction (AMI)
EDAC-30-HF	EDAC after hospitalization for Heart Failure (HF)
OP-32	Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
OP-35 ADM	Admissions Visits for Patients Receiving Outpatient Chemotherapy
OP-35 ED	Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
OP-36	Hospital Visits after Hospital Outpatient Surgery

Patient Experience (N=8)

Measure	Description
H-COMP-1	Communication with Nurses (Q1, Q2, Q3)

Measure	Description
H-COMP-2	Communication with Doctors (Q5, Q6, Q7)
H-COMP-3	Responsiveness of Hospital Staff (Q4, Q11)
H-COMP-5	Communication About Medicines (Q16, Q17)
H-COMP-6	Discharge Information (Q19, Q20)
H-COMP-7	Care Transition (Q23, Q24, Q25)
H-CLEAN-HSP/H-QUIET-HSP	Cleanliness of Hospital Environment (Q8) & Quietness of Hospital Environment (Q9)
H-HSP-RATING/H-RECMND	Hospital Rating (Q21) & Recommend the Hospital (Q22)

Timely & Effective Care (N=13)

Measure	Description
HCP COVID-19	COVID-19 Vaccination Coverage Among Healthcare Personnel
IMM-3	Healthcare Personnel (HCP) Influenza Vaccination
OP-10	Abdomen Computed Tomography (CT) Use of Contrast Material
OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-22	ED-Patient Left Without Being Seen
OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival
OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
OP-8	MRI Lumbar Spine for Low Back Pain
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation
SEP-1	Sepsis
Safe Use of Opioids	Safe Use of Opioids-Concurrent Prescribing

The methodology finalized in 2021uses a simple average of measure scores to calculate measure group scores and Z-score standardization to standardize measure group scores for the following:

- Mortality
- Safety of Care
- Readmission
- Patient Experience
- Timely & Effective Care

After estimating the group score for each hospital and each group, CMS calculates a weighted average to combine the five group scores into a single hospital summary score. If a hospital is missing a measure category or group, the weights are redistributed proportionally amongst the qualifying measure categories or groups.

After summary score calculation, hospitals are assigned to one of three peer groups based on the number of measure groups for which they report at least three measures; three measure groups, four measure groups, or five measure groups.

Finally, hospitals are assigned to star ratings within each peer group using k-means clustering so that summary scores in one star rating category are more similar to each other and more different than summary scores in other star rating categories.

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 April 2025 Overall Hospital Quality Star Rating HSRs along with the October 2024 Hospital Inpatient and Outpatient Quality Reporting Program Preview data.

These HSRs are provided when the Overall Hospital Quality Star Rating is recalculated annually.

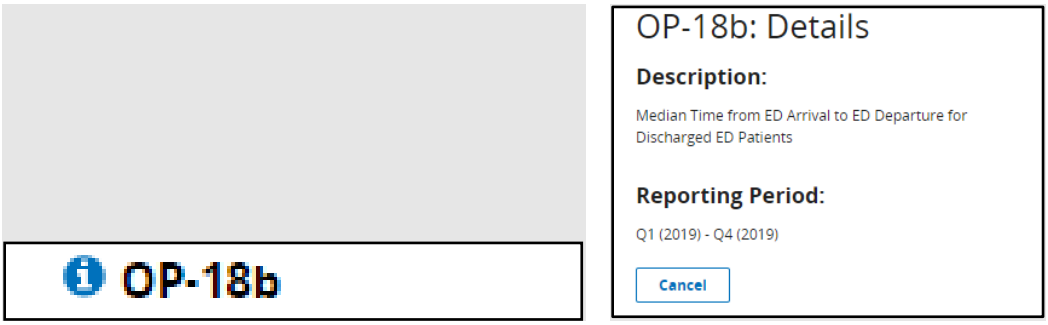
Measure Data Tab

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

If the user has access to inpatient and outpatient data, then the measures for both programs will display for review.

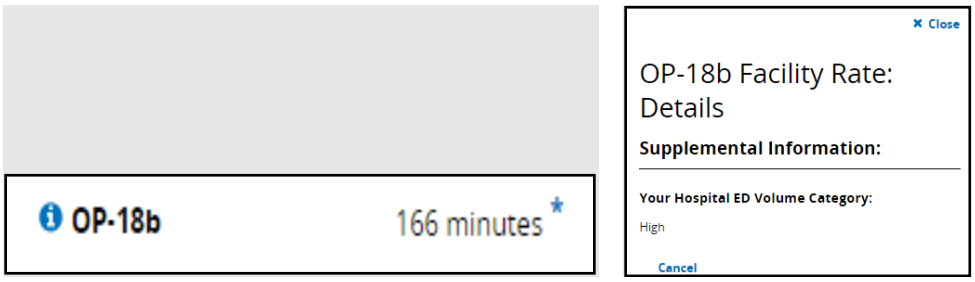
The accordions are labeled similarly to the tabs on the Compare tool on Medicare.gov and can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

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

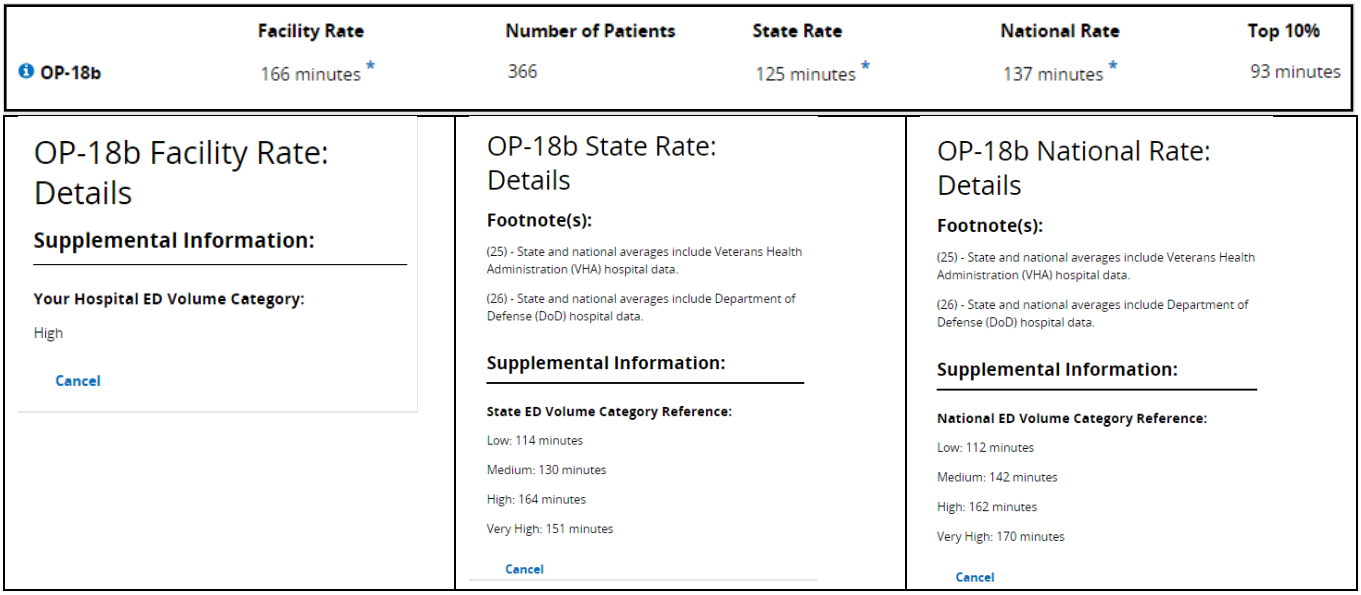


Data display with an asterisk (*). Selecting the data value by the asterisk will pop up a modal with additional details about the data such as a footnote.

For the Emergency Department Care measures, the facility's Emergency Department Volume (EDV) category, which ranges from "low" (less than or equal to 19,999 patients per year) to "very high" (60,000 or greater patients per year), is provided within the facility rate modal to be used as a reference to compare like-facility EDV times within the state and the nation.



To view the state information, select the **State** data next to the asterisk. To view the national information, select the **National** data next to the asterisk.



Within the Preview UI, facilities have the ability to filter. In the below scenario, the filter for **Release** is selected. The accordions will then appear, and facilities can see the measures that meet these requirements.

PR Data Details

Hospital Characteristics

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

Type of ownership is publicly available only in the downloadable database on the data catalog found on [data.cms.gov/provider-data/.](data.cms.gov/provider-data/)

If the displayed hospital characteristics are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reports agency coordinator to correct the information. Submitted corrections may not be reflected in the next Compare refresh. For questions regarding the ASPEN state contact list for hospitals, please refer to these CMS Minimum Data Set Contacts.

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.)

Accordions

+Timely and Effective Care
Emergency Department (OP-18b, OP-18c, OP-22, OP-23)
Healthcare Personnel Vaccination (HCP COVID-19)
Cardiac Care (OP-40 voluntary)
Cataract Care (OP-31)
Colonoscopy (OP-29)

Emergency Department Measures

The Emergency Department (ED) section of the preview UI displays the ED measures.

Measures OP-18b, OP-18c, OP-23 contain up to four quarters of data and display as a median time. They are calculated from all payer patient encounter data submitted for a hospital. OP-22 data are entered annually into a web-based tool in the HQR system by your hospital.

ED measures include:

- OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Psychiatric/Mental Health 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.

OP-18b, OP-18c, OP-22, and OP-23 display the following data:

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

- Top 10%

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-18b	202 minutes *	516	119 minutes *	160 minutes *	100 minutes *
OP-18c	389 minutes *	50	202 minutes *	267 minutes *	131 minutes *
OP-22	7%	110,845	3% *	3% *	0% *
OP-23	71%	42	68% *	69% *	100% *

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

The EDV information displays based on the volume of patients submitted by a hospital as the denominator used for 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

State and National Performance Rates

The state and national performance rates for ED measures are calculated using publicly reported data from the Clinical Warehouse.

State Performance: The state performance rate is derived by summing the numerators for all cases in the state that are publicly reported divided 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.

National Performance: 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. 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.

Healthcare Personnel Vaccination Measure

COVID-19 Vaccination

The COVID-19 Vaccination Among Healthcare Personnel (HCP COVID-19) reflects data provided by the Centers for Disease Control and Prevention (CDC) for public reporting. Each quarter, CDC will calculate quarterly HCP COVID-19 vaccination coverage rates for each facility by taking the average of the data from three weekly rates submitted by the facility for that quarter. For facilities that report more than one week per month, the last week of the reporting month will be used. The data will reflect a single quarter of data in each quarterly release. April 2025 release will display Q2 2024 data.

Note: For the CDC to provide a facility's HCP COVID-19 vaccination data for public reporting, facilities should submit data for at least one week per month for the reporting quarter. In NHSN, the last day of the reported week determines the month. For example, data submitted for the week of April 29 –through May 5, 2024, counts for May, not April. For Q2 of 2024, unless there is at least one week

of data that ends in April, one week of data that ends in May, and one week of data that ends in June, NHSN will not send a hospital's HCP COVID-19 vaccination data to CMS.HCP COVID-19 displays the following data:

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

Healthcare Personnel Vaccination			
	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
HCP_COVID-19	3%	17.4%	15.6%

Facility's Adherence Rate

The COVID-19 HCP Vaccination Adherence Percentage is calculated as the total number of reported eligible healthcare personnel with Up to Date vaccination against COVID-19 divided by the total number of reported eligible healthcare workers among whom COVID-19 vaccination was not contraindicated per CDC's NHSN data collection instructions.

Eligible providers are defined as the number of healthcare workers who have worked at the healthcare facility for at least one day during the reporting week of data collection period regardless of clinical responsibility or patient contact.

State Adherence Rate

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

The denominator excludes HCP for whom COVID-19 vaccination was contraindicated per CDC's NHSN data collection instructions.

National Adherence Rate

National Adherence Rates are calculated as the total number of reported healthcare workers in the nation contributing to successful vaccination adherence divided by the total number of healthcare workers in the nation. The denominator excludes HCP for whom COVID-19 vaccination was contraindicated per CDC's NHSN data collection instructions.

Cardiac Care

OP-40 (voluntary): ST-Segment Elevation Myocardial Infarction (STEMI) displays up to four quarters of data, displayed as an aggregate rate and based on data submitted via electronic health record (EHR). The data will be updated annually 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.

Note: 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 site.

Performance Rates

OP-40 measure displays:

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

State Rate

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

Note: The state performance rates displayed on the preview report is for informational purposes. CMS will not publicly report the state performance rate at this time.

National Rate

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

Note: 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.

Top 10%

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.

Note: 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.

Cardiac Care					
	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-40	N/A *	N/A *	N/A *	46%	69%

Cataracts Measure

OP-31(voluntary): Cataracts-Improvement in Patient's Visual Function within 90 Days Following Cataracts Surgery. The OP-31 measure displays:

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

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-31	10% *	120 *	12% *	20% *	12%

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

Performance Rates

The performance rates for the Cataract Visual Function Measure are calculated using publicly reported data from the Clinical Warehouse.

Facility Rate: 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.

State Rate: 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.

National Rate: 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.

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

Colonoscopy Measure

The Colonoscopy measure is OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. This measure displays:

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

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-29	15% *	8900	68% *	79% *	29%

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

Performance Rates

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).

Facility Rate: 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.

State Rate: 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.

National Rate: 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.

Top 10%: The 90th percentile is calculated for each measure 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

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

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/Ratio	National Rate/Ratio	National Compare
OP-32	375	19.2*	16.4*	SAME
OP-35_ADM	380	N/A*	12.5*	SAME
OP-35_ED	380	N/A*	6*	SAME
OP-36	400	1*	N/A*	SAME

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.

The OP-35 Admissions (ADM) and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy-Risk Standardized Admission & ED Rate measure provides facilities with information to improve the quality of care delivered for patients undergoing outpatient chemotherapy treatment. The measure 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. OP-36 is calculated using one year of data.

+ Use of Medical Imaging

Imaging Efficiency (OP-8, OP-10, OP-13, OP-39)

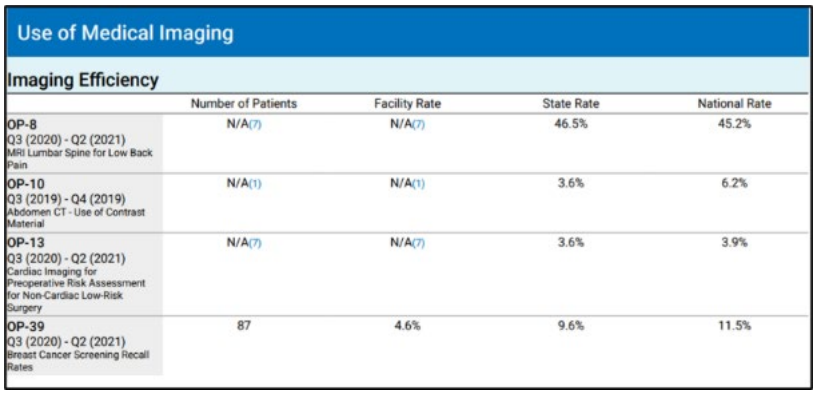
Use of Medical Imaging Measures

Use of Medical Imaging 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. Use of Medical Imaging measures include:

- OP-8: MRI Lumbar Spine for Low Back Pain
- OP-10: Abdomen CT–Use of Contrast Material
- OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery
- OP-39: Breast Cancer Screening Recall Rates

Each measure displays:

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



Use of Medical Imaging

Imaging Efficiency

	Number of Patients	Facility Rate	State Rate	National Rate
OP-8 Q3 (2020) - Q2 (2021) MRI Lumbar Spine for Low Back Pain	N/A(7)	N/A(7)	46.5%	45.2%
OP-10 Q3 (2019) - Q4 (2019) Abdomen CT - Use of Contrast Material	N/A(1)	N/A(1)	3.6%	6.2%
OP-13 Q3 (2020) - Q2 (2021) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	N/A(7)	N/A(7)	3.6%	3.9%
OP-39 Q3 (2020) - Q2 (2021) Breast Cancer Screening Recall Rates	87	4.6%	9.6%	11.5%

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.

State and National Performance Rates

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

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient's Experience	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness of Hospital Environment Quietness of Hospital Environment Discharge Information Care Transition Hospital Rating Recommend this Hospital
Timely and Effective Care	Sepsis (SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR) Emergency Department Care (ED-2-Strata-1, ED-2-Strata-2, OP-18b, OP-18c, OP-22, OP-23) Healthcare Personnel Vaccination IMM-3, HCP COVID-19, IPFQR-HCP COVID-19, PCH-28. PCH-38) Cardiac Care (OP-40) Cataract (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, STK-06) Hospital Harm (HH-01, HH-02)
Maternal Health	Structural Measures [Maternal Morbidity Structural Measure (SM-7)] Perinatal Care (ePC-02, PC-05, ePC-07a, ePC-07b)
Health Equity	Hospital Commitment to Health Equity (HCHE)
Complications & Deaths	30-Day Death Rates (MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG) CMS Patient Safety Indicators (PSI 03, PSI 04, PSI 06, PSI 08, PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, PSI 15, PSI 90) M 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)

Measure Accordion	Measure IDs Included
Unplanned Hospital Visits	Condition Specific Readmission (READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD) Procedure Specific Readmission (READM-30-CABG, READM-30-HIP-KNEE) Hospital Wide Readmission (READM-30-HOSPWIDE) Inpatient Psychiatric Facility Readmission (READM-30-IPF) Procedure Specific Outcomes (PCH-30, PCH-31, OP-32, OP-35 ADM, OP-35 ED, OP-36) Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)
Payment & Value of Care	Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE) Medicare Spending per Beneficiary (MSPB-1)
Follow-Up Care	Transition Record (TR1, TR2) Follow-Up After Psychiatric Hospitalization (FAHH-7, FAHH-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-8, OP-10, OP-13, OP-39)
Palliative Care	End-of-Life (EOL) Measures (PCH-32, PCH-33, PCH-34, PCH-35)
Patient Reported Outcome	THA/TKA Inpatient Pre-operative Surveys only (THA/TKA PRO-PM)

Footnote Table

Number	Description	Application
1	The number of cases/ patients is too few to report	Applied to any measure rate where the denominators are greater than 0 and less than 11. Data will not display on the Compare tool on Medicare.gov. For HCAHPS: • This is applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges. • HCAHPS scores based on fewer than 25 completed surveys will display on the Preview UI. • Data will not display on the Compare tool on Medicare.gov. Measures based on claims data and eCQM data: Applied to any hospital where the number of cases reported is too small (less than 25 and greater than zero) to reliably tell how well a hospital is performing.
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 (e.g., VTE)
3	Results are based on a shorter time period than required	Applied when a hospital 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	Reserved for CMS use.
5	Results are not available for this reporting period	Applied when a hospital either elected not to submit data, or the hospital had no data to submit for a particular measure, or when a hospital elected to suppress a measure. For HCAHPS: • When a hospital did not participate in HCAHPS reporting during the period covered by the applicable Preview UI • When a hospital only participated in HCAHPS reporting for a portion of the period covered by the applicable Preview UI • When a hospital chooses to suppress HCAHPS results (A hospital will see HCAHPS results on

Number	Description	Application
		its Preview UI, but not on the Compare tool on Medicare.gov.)
6	Fewer than 100 patients completed the HCAHPS survey (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS surveys is 50–99.
7	No cases met the criteria for this measure	Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
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 hospitals in a state/territory had data available. OR • No data was reported for this state/territory.
10	• Very few patients were eligible for the HCAHPS survey • The scores shown reflect fewer than 50 completed surveys (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS surveys is fewer than 50.
11	There were discrepancies in the data collection process	Applied when there have been deviations from HCAHPS data collection protocols.

Number	Description	Application
12	This measure does not apply to this hospital for this reporting period	Applied to the measure when either the hospital has a waiver, or the hospital submitted to NHSN: • Zero Central Line Days • Zero Catheter Days • Zero Surgical Procedures
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.	Applied when CMS has determined there are too few cases or patients to report an HCAHPS Star Rating.
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

Number	Description	Application
		• Did not report data for at least one outcomes measure group.
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. The hospital or facility has reported discrepancies in their claims data.	This footnote is applied when a hospital or facility alerts CMS of a possible issue with the claims 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 after the snapshot are not reflected in the data. Issues with claims 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 is included in the calculation.
26	State and national averages include DoD hospital data.	Applied to state and national data when DoD data is 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.

Number	Description	Application
		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.

Questions

Managed File Transfer is not intended for question submission.

Questions regarding the Overall Hospital Quality Star Ratings may be directed to the Overall Hospital Quality Star Ratings Team via the QualityNet Question and Answer Tool.

Questions regarding the Hospital OQR Program to the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support Team via the QualityNet Question and Answer Tool or call, toll-free, (866) 800-8756 weekdays from 7 a.m. to 6 p.m. Eastern Time.