Inpatient Public Reporting Preview Help Guide

February 2025 Public Reporting Preview/April 2025 Public Reporting Release

Hospital staff are the target audience for this publication.
The document scope is limited to instructions for hospitals to access and interpret the data provided on the Public Reporting Preview User Interface (UI) prior to publication of the data on the Compare tool on Medicare.gov.

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Overview

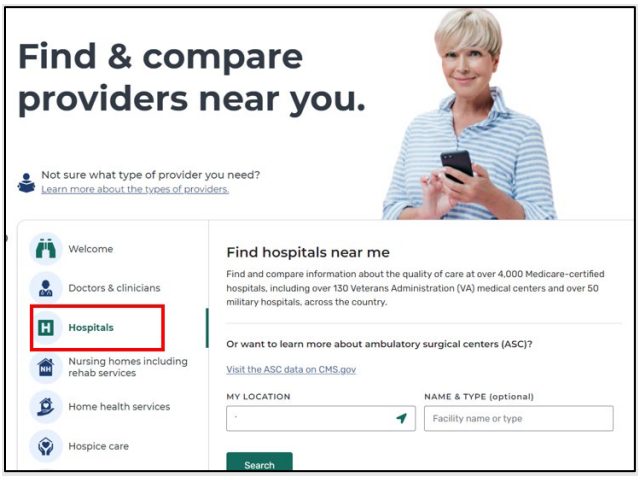
The Compare Tool on Medicare.gov

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

Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates. Section 1886(g) of the Social Security Act requires the Secretary of United Stated Department of Health and Human Services to pay for the capital-related costs of inpatient hospital services under the IPPS.

Under the IPPS, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of Medicare Severity Diagnosis-Related Groups. Hospitals paid under the IPPS are subject to a one-fourth reduction of the annual payment update if Hospital IQR Program requirements are not met for each fiscal year. Hospitals not paid under the IPPS that voluntarily submit data for one or more measures may choose to have any or all of the information displayed on the Compare tool on Medicare.gov. In alignment with the Hospital IQR Program, the Medicare Promoting Interoperability Program is publicly reporting eCQM data submitted by eligible hospitals and critical access hospitals.

Public Reporting Preview UI

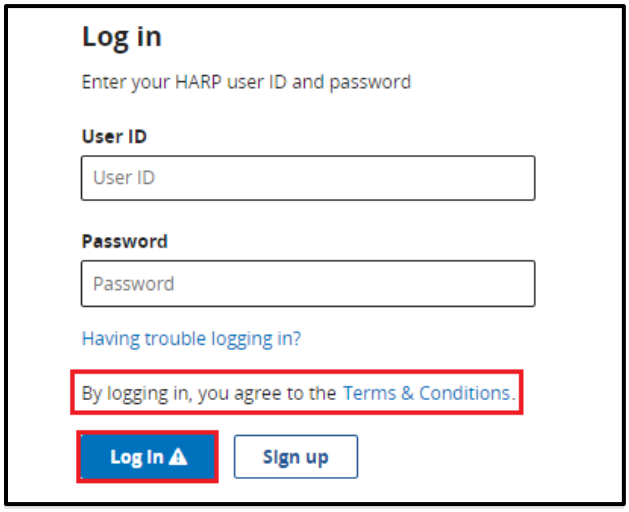
The Preview UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to the Compare tool on Medicare.gov.

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.

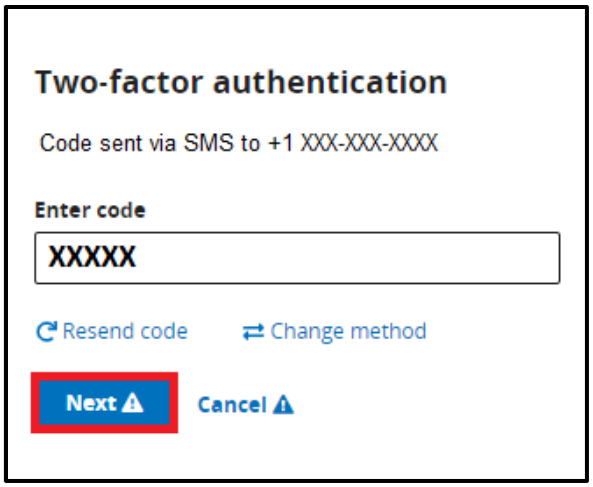
The HQR system no longer supports the use of Internet Explorer. To avoid technical issues when logging into the HQR system, please use either Google Chrome or Microsoft Edge.

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**.

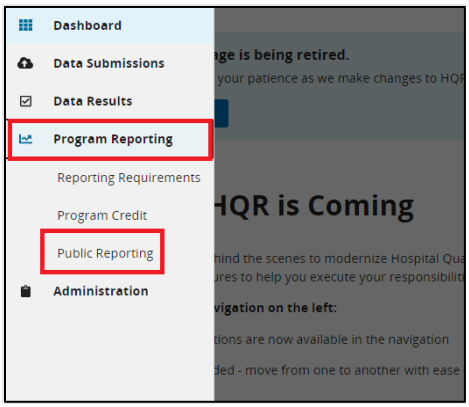


3. You will be directed to the **Two-Factor Authorization** page. Select the device you would like to verify via **Text** or **Email.** Select **Next**.
4. Once you receive the code via **Text** or **Email**, enter it. Select **Next**.



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

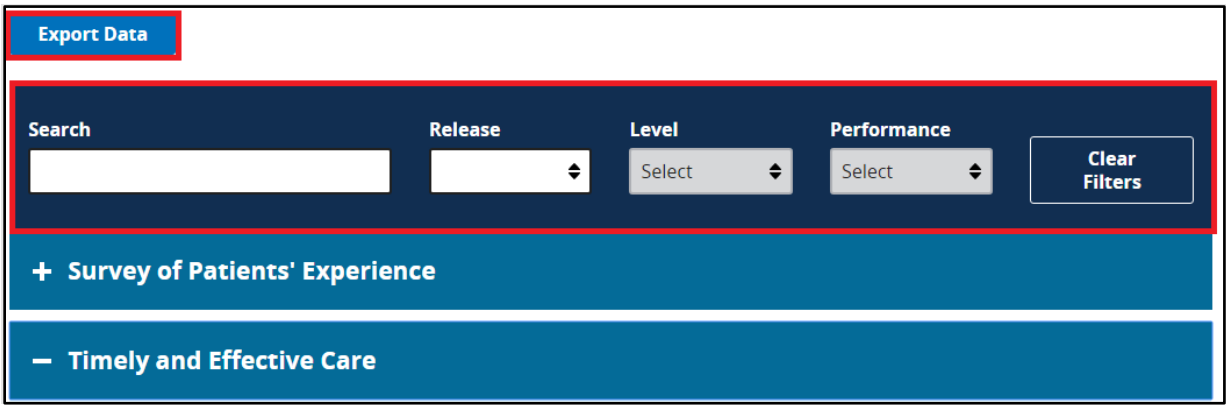
6. Select **Program Reporting.** From the drop-down menu, select **Public Reporting.** The page will refresh, and the data will be available to preview.



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.

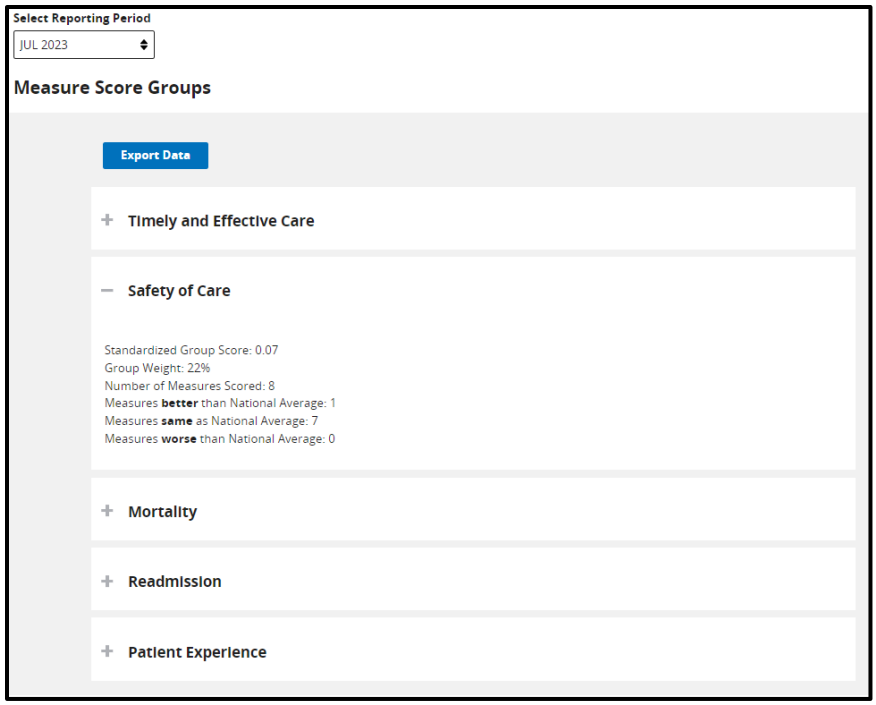
Filtering - Users will be able to filter their benchmark data in the following ways:

- 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.

Public Reporting Data Details

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 the Compare tool on Medicare.govthe Compare tool on Medicare.govthe Compare tool on Medicare.govin 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 the Compare tool on Medicare.govthe Compare tool on Medicare.govthe Compare tool on Medicare.govin 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)
H-COMP-2	Communication with Doctors (Q5, Q6, Q7)

Measure	Description
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)

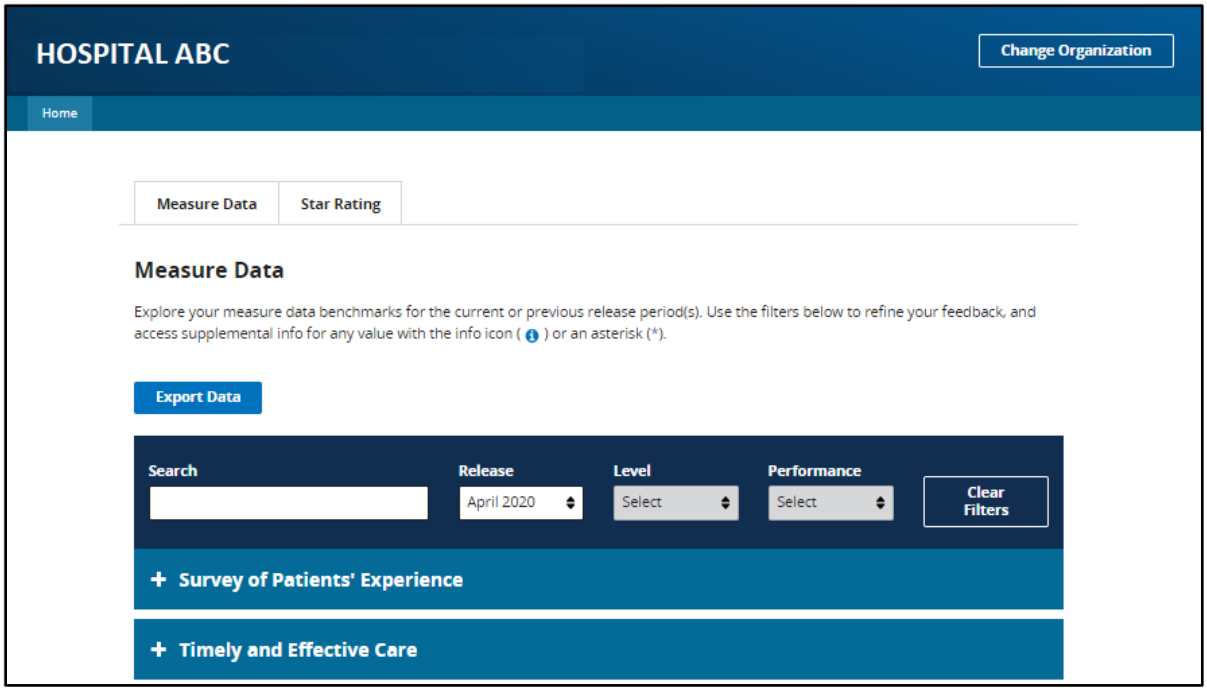
The Overall Hospital Quality Star Rating HSR contains hospital-specific Overall Star Rating and national results, hospital-specific measure group score results and weights, hospital-specific measure score results, and hospital-specific peer grouping for the reporting period. Hospitals are

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.

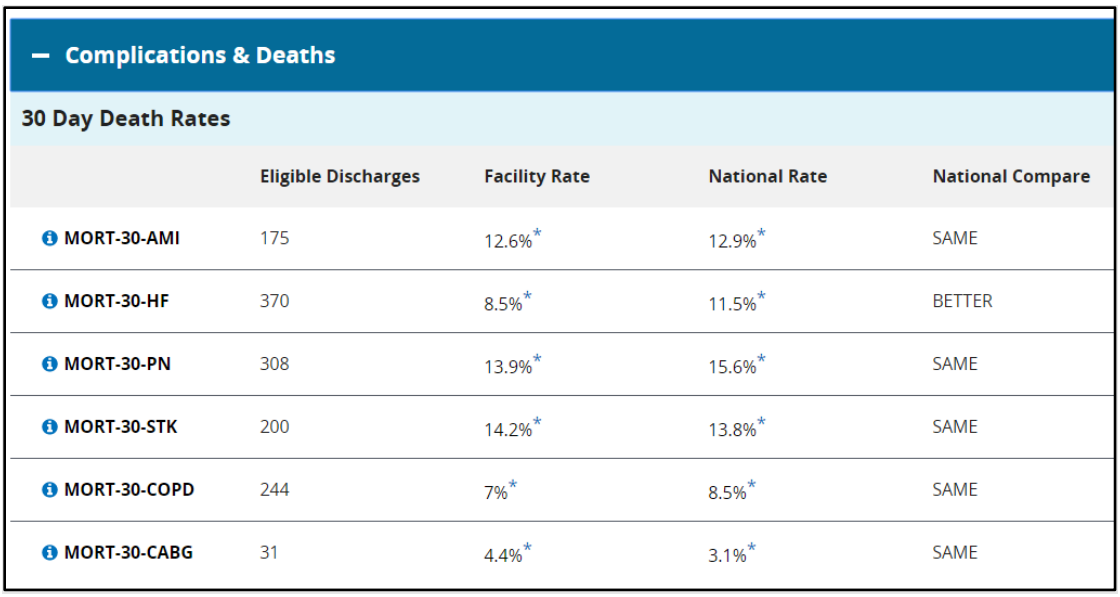
These HSRs are provided when the Overall Hospital Quality Star Rating is recalculated annually.

Measure Data Tab

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

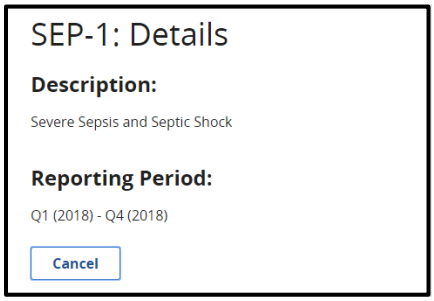


– Complications & Deaths

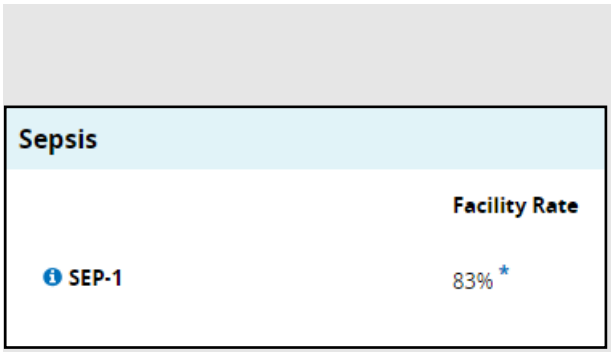
30 Day Death Rates

	Eligible Discharges	Facility Rate	National Rate	National Compare
MORT-30-AMI	175	12.6%*	12.9%*	SAME
MORT-30-HF	370	8.5%*	11.5%*	BETTER
MORT-30-PN	308	13.9%*	15.6%*	SAME
MORT-30-STK	200	14.2%*	13.8%*	SAME
MORT-30-COPD	244	7%*	8.5%*	SAME
MORT-30-CABG	31	4.4%*	3.1%*	SAME

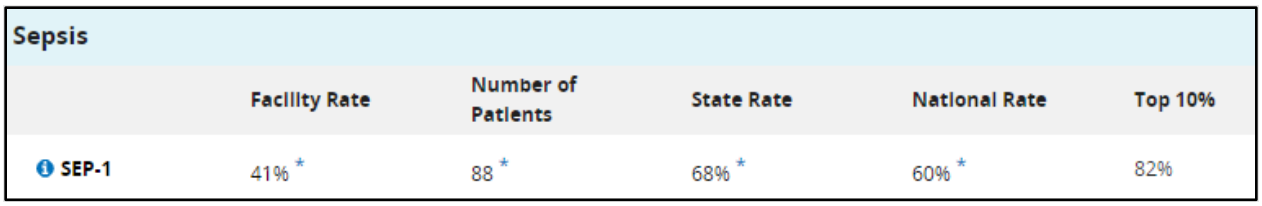
Select the info icon ( ) to the left of the measure ID to display the full measures description in a modal.



Data display with an asterisk (*). Selecting the data value by the asterisk will reveal a modal with additional details about the data (e.g., a footnote).



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 which measures meet these requirements. The Level and Performance filters are not active yet.

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/.

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

+Survey of Patients' Experience

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient Experience Data (HCAHPS)

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

The HCAHPS Survey data displays 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.

Note: The HCAHPS scores contained in the April 2025 Public Reporting Preview Report are based on patients discharged between July 1, 2023, and June 30, 2024.

HCAHPS Star Ratings

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 10 HCAHPS measures and the HCAHPS Summary Star Rating, a single summary statistic of all the HCAHPS Star Ratings. The Preview dataset also contain the linear mean scores that are used in the calculation of the HCAHPS Star Ratings. For more information on HCAHPS Star Ratings and linear mean scores, please see the HCAHPS Star Ratings section on the HCAHPS website, https://hcahpsonline.org/en/hcahps-star-ratings/ .

- HCAHPS Composites
  - Composite 1 – Communication with Nurses (Question Q1, Q2, Q3)
    - Q1 – Nurse Courtesy & Respect
    - Q2 – Nurse Listen
    - Q3 – Nurse Explain
  - Composite 2 – Communication with Doctors (Q5, Q6, Q7)
    - Q5 – Doctor Courtesy & Respect
    - Q6 – Doctor Listen
    - Q7 – Doctor Explain
  - Composite 3 – Responsiveness of Hospital Staff (Q4, Q11)
    - Q4 – Call Button
    - Q11 – Bathroom Help
  - Composite 5 – Communication about Medicines (Q13, Q14)
    - Q13 – Medicine Explain
    - Q14 – Side Effects
- Hospital Environment Items
  - Cleanliness of Hospital Environment (Q8)

    - Quietness of Hospital Environment (Q9)
- Discharge Information Composite
    - Composite 6 – Discharge Information (Q16, Q17)
        - Q16 – Help After Discharge
        - Q17 – Symptoms
- Care Transition Composite
    - Composite 7 – Care Transition (Q20, Q21, Q22)
        - Q20 – Preferences
        - Q21 – Understanding
        - Q22 – Medicine Purpose

The HCAHPS Global Items include:

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

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

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

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the six composite measures, two environment items, and two global items. Scores are available in the data catalog on data.cms.gov.

Survey of Patients' Experience

Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.

HCAHPS individual question scores based on fewer than 50 completed surveys **will not** be reported in the downloadable database.

HCAHPS Summary Star Rating ★★★★★	Q4 (2017) - Q3 (2018)
Completed Surveys	1,164
Survey Response Rate	30%

More Stars are better.
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"
*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Communication with Nurses Q4 (2017) - Q3 (2018)
★★★★★ Linear Score (1 - 100): 94

Composite (Q1 - Q3)	Facility	State	National
Always	84%	76%	80%
Usually	14%	17%	16%
Sometimes/Never	2%	7%	4%

Nurse Courtesy & Respect (Q1)	Facility	State	National
Always	91%	83%	87%
Usually	8%	13%	10%
Sometimes/Never	1%	4%	3%

State and National Average Rates

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

HCAHPS Individual Question Scores

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

- Hospitals must have at least 50 completed surveys for individual question scores to be shown in the downloadable database.

HCAHPS individual question scores will NOT be reported on the Compare tool on Medicare.gov. These individual question scores are included in the Preview UI and data catalog on data.cms.gov downloadable database:

- Q1 – Nurse Courtesy & Respect
- Q2 – Nurse Listen
- Q3 – Nurse Explain
- Q4 – Call Button
- Q5 – Doctor Courtesy & Respect
- Q6 – Doctor Listen
- Q7 – Doctor Explain
- Q11 – Bathroom Help
- Q13 – Medicine Explain
- Q14 – Side Effects
- Q16 – Help After Discharge
- Q17 – Symptoms
- Q20 – Preferences
- Q21 – Understanding
- Q22 – Medicine Purpose

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

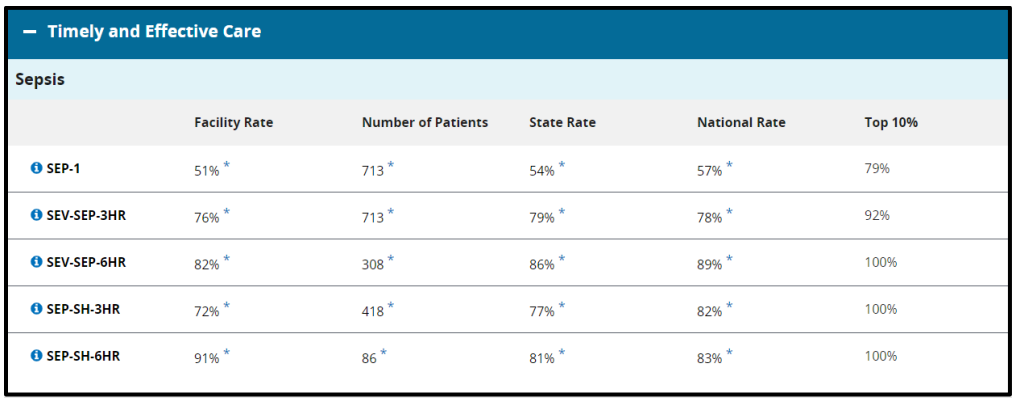
+Timely and Effective Care
Sepsis (SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR)
Emergency Department Care (ED-2-Strata-1, ED-2-Strata-2)
Healthcare Personnel Vaccination (IMM-3, HCP COVID-19))
Opioid Use (Safe Use of Opioids-Concurrent Prescribing)
Venous Thromboembolism (VTE-1, VTE-2)
Stroke Care (STK-02, STK-03, STK-05, STK-06)
Hospital Harm (HH-01, HH-02)

Sepsis

The Severe Sepsis and Septic Shock (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 and facility-level preview

reports that began being reported with the January 2020 release. SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR, display the following data:

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



– Timely and Effective Care

Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1	51% *	713 *	54% *	57% *	79%
SEV-SEP-3HR	76% *	713 *	79% *	78% *	92%
SEV-SEP-6HR	82% *	308 *	86% *	89% *	100%
SEP-SH-3HR	72% *	418 *	77% *	82% *	100%
SEP-SH-6HR	91% *	86 *	81% *	83% *	100%

Denominators greater than 0 and less than 11 will display on the Preview UI but not 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 your hospital elected to opt-out of publicly reporting data on the Compare tool on Medicare.gov.

State Rate

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.

National Rate

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.

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.

Emergency Department Care

The Emergency Department Care section of the preview report displays the ED-2 measure. The measure results are an aggregate of up to four quarters of data, calculated from data submitted via an electronic health record (EHR) and displayed as a median time.

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. The ED-2 measure is reported for two populations or strata:

- ED-2-Strata-1 (Admit Decision Time to ED Departure Time for Admitted Patients-non psychiatric/mental health disorders)

- ED-2-Strata-2 (Admit Decision Time to ED Departure Time for Admitted Patients – psychiatric/mental health disorders)

ED-2-Strata-1 and ED-2-Strata-2 display the following data:

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

Denominators greater than 0 and less than 25 will display on the Preview UI but not the data catalog on data.cms.gov.

State Rate

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. Median times are identified using all cases 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 cases in the nation divided by the sum of the denominators in the nation. Median times are identified using all cases 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.

Healthcare Personnel Vaccination Measures

Influenza Vaccination

Healthcare Personnel Influenza Vaccination (IMM-3) includes the number of healthcare personnel 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.

COVID-19 Vaccination

The HCP COVID-19 measure 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. The April 2025 release displays 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.

IMM-3 and HCP COVID-19 display 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
IMM-3	74%	60%	80%
HCP_COVID-19	6%	4%	11.6%

Facility's Adherence Rate

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

The HCP COVID-19 Vaccination Adherence Percentage is calculated as the total number of eligible healthcare personnel with Up-to-Date vaccination against COVID-19 divided by the total number of eligible healthcare personnel among whom COVID-19 vaccination was not contraindicated per CDC's NHSN data collection instructions. Eligible healthcare personnel are defined as the number of healthcare personnel who are scheduled to work in the facility for at least one day every week regardless of clinical responsibility or patient contact.

State Adherence Rate

State Adherence Rates are calculated as the total number of healthcare personnel in the state contributing to successful vaccination adherence divided by the total number of healthcare personnel in the state. For the HCP COVID-19 Vaccination State Adherence Rate, 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 healthcare personnel in the nation contributing to successful vaccination adherence divided by the total number of healthcare personnel in the nation. For the HCP COVID-19 Vaccination National Adherence Rate, the

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

Opioid Use

The Opioid Use section of the preview report displays the eCQM Safe Use of Opioids measure and displays up to four quarters of data, displayed as an aggregate rate, calculated from data submitted via an EHR.

Note: Beginning with the October 2024 Care Compare release, the facility state and national level data displayed on the preview report will be included in the Timely and Effective Care downloadable databases on the data catalog on data.cms.gov site and the Compare tool on Medicare.gov

The Safe Use of Opioid Measure displays the following data:

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

Denominators greater than 0 and less than 25 will display on the Preview UI but not on the data catalog on data.cms.gov or the Compare tool on Medicare.gov.

State Rate

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.

National Rate

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.

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.

Venous Thromboembolism

The Venous Thromboembolism (VTE) section of the preview report displays eCQM VTE measures and includes up to four quarters of data, displayed as an aggregate rate calculated from data submitted via an EHR.

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.

VTE measures include:

- VTE-1 (Venous Thromboembolism Prophylaxis)

- VTE-2 (Intensive Care Unit Venous Thromboembolism Prophylaxis)

VTE measures display the following data:

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

Denominators greater than 0 and less than 25 will display on the Preview UI but not in the data catalog on data.cms.gov.

State Rate

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.

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 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.

Stroke Care

The Stroke Care section of the preview report displays stroke measures and displays up to four quarters of data, displayed as an aggregate rate calculated from data submitted via an EHR.

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. Stroke measures include:

- STK-02 (Discharged on Antithrombotic Therapy)
- STK-03 (Anticoagulation Therapy for Atrial Fibrillation/Flutter)
- STK-05 (Antithrombotic Therapy by the End of Hospital Day Two)
- STK-06 (Discharged on Statin Medication)

Stroke measures display the following data:

- Facility Rate
- Number of Patients
- State Rate

- National Rate
- Top 10%

Denominators greater than 0 and less than 25 will display on the Preview UI but not in the data catalog on data.cms.gov.

State Rate

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.

Note: 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.

National Rate

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.

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.

Hospital Harm

The Hospital Harm section of the preview report displays HH-01 and HH-02 glycemia measures and includes up to four quarters of data, displayed as an aggregate rate calculated from data submitted via an EHR.

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.

Hospital Harm measures include:

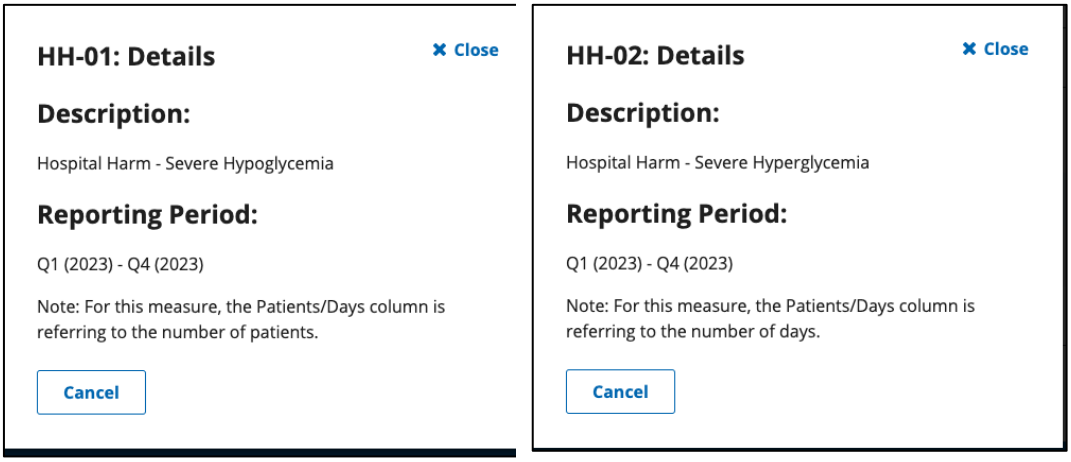
- HH-01 (Hospital Harm-Severe Hypoglycemia)
- HH-02 (Hospital Harm-Severe Hyperglycemia)

Hospital Harm measures display the following data:

- Facility Rate
- Patients/Days
- State Rate
- National Rate
- Top 10%

Hospital Harm					
	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
HH-01	58%	81	58%	58%	58%
HH-02	9%	509	9%	9%	9%

Modals provide the different facility details for each measure.



Denominators greater than 0 and less than 25 will display on the Preview UI but not in the data catalog on data.cms.gov.

State Rate

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.

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 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.

+Maternal Health
Maternal Morbidity Structural Measure (SM-7) Perinatal Care (ePC-02, PC-05, ePC-07a, ePC-07b)

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?"

The Maternal Morbidity Structural Measure is updated annually during the October public reporting release. October 2023 was the first time a full calendar year of data were reported.

Data display response options:

- Yes
- No
- Not Applicable

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

Beginning with the October 2023 public reporting release, providers who submitted the response "Yes" had 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

Perinatal Care Measures include:

- ePC-02 (Cesarean Birth)
- ePC-07a (Severe Obstetric Complications)
- ePC-07b (Severe Obstetric Complications without blood transfusions)
- PC-05 (Exclusive Breast Milk Feeding)

The ePC-02, PC-05, ePC-07a, and ePC-07b measures display up to four quarters of data, displayed as an aggregate rate, calculated from data submitted via an 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**: SM-7, ePC-02, PC-05, ePC-07a, and ePC-07b are displayed in the Maternal Health – Hospital downloadable databases on the data catalog on data.cms.gov. Only SM-7 will display on the Compare tool on Medicare.gov.

However, the facility level ePC-02, PC-05, ePC-07a, and ePC-07b data displayed on the preview report will **only** be included in the downloadable database available on the data catalog on data.cms.gov site. Measures display:

- 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 cases in the state divided by the sum of the denominators in the state.

- The state rates for ePC-02, PC-05, ePC-07a, and ePC-07b are provided as informational purposes and will not be publicly reported at this time.

National Rate

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 national rates for ePC-02, PC-05, ePC-07a, and ePC-07b are provided for informational purposes and will not be publicly reported 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.

- The top 10% for ePC-02, PC-05, ePC-07a, and ePC-07b are for informational purposes and will not be publicly reported at this time.

+ Health Equity

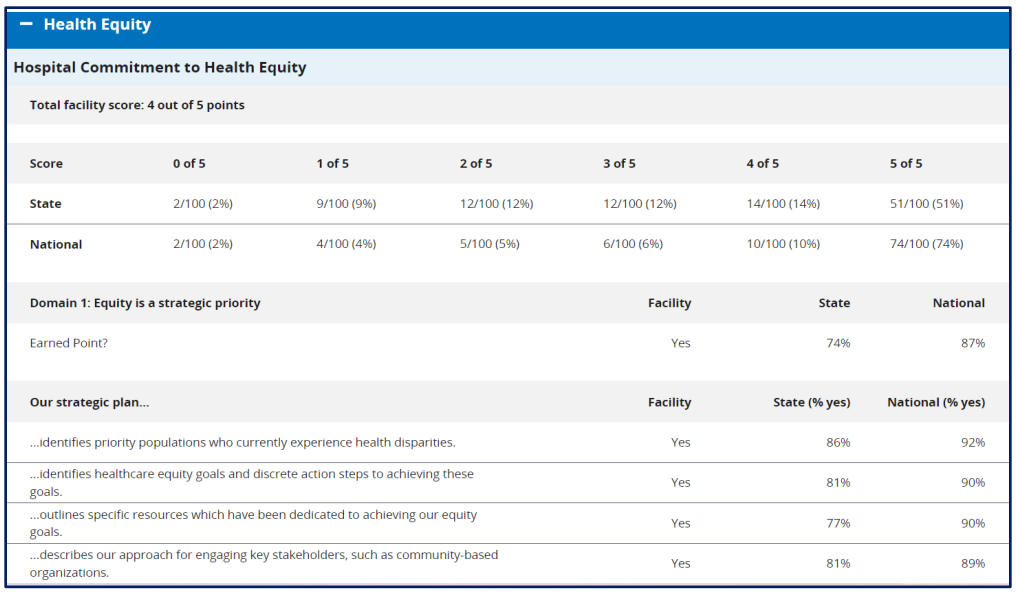
Hospital Commitment to Health Equity (HCHE)

Hospital Commitment to Health Equity

The Hospital Commitment to Health Equity (HCHE) measure includes five attestation-based domains of commitment. For each domain, there are multiple elements to which a hospital must attest. Hospitals receive one point for each domain to which they affirmatively attest to all questions in the domain, stating they are meeting the required competencies. A hospital's score can be a total of zero to five points (one per domain). Hospitals will only receive one point for each domain if they affirmatively attest to all related sub-questions. If hospitals do not affirmatively attest to a sub-question, they will not receive a point for that domain.

The preview report will display the facility overall score, numerator/denominator and respective state and national percent scores.

The preview will display the provider’s response to each domain and the percent of providers with positive responses in the state and the nation for each of the subset of questions.



Health Equity

Hospital Commitment to Health Equity

Total facility score: 4 out of 5 points

Score	0 of 5	1 of 5	2 of 5	3 of 5	4 of 5	5 of 5
State	2/100 (2%)	9/100 (9%)	12/100 (12%)	12/100 (12%)	14/100 (14%)	51/100 (51%)
National	2/100 (2%)	4/100 (4%)	5/100 (5%)	6/100 (6%)	10/100 (10%)	74/100 (74%)

Domain 1: Equity is a strategic priority	Facility	State	National
Earned Point?	Yes	74%	87%

Our strategic plan...	Facility	State (% yes)	National (% yes)
...identifies priority populations who currently experience health disparities.	Yes	86%	92%
...identifies healthcare equity goals and discrete action steps to achieving these goals.	Yes	81%	90%
...outlines specific resources which have been dedicated to achieving our equity goals.	Yes	77%	90%
...describes our approach for engaging key stakeholders, such as community-based organizations.	Yes	81%	89%

Domains and subset questions are:

- Domain 1: Equity is a strategic priority.
  - Our strategic plan…
    - Identifies priority populations who currently experience health disparities.
    - Identifies healthcare equity goals and discrete action steps to achieving these goals.
    - Outlines specific resources which have been dedicated to achieving our equity goals.
    - Describes our approach for engaging key stakeholders such as community-based organizations.
- Domain 2: Data collection.
  - Our hospital…
    - Collects demographic information (such as self-reporting race, national origin, primary language, and ethnicity data) and/or social determination of health information on the majority of our patients.
    - Has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
    - Inputs demographic and/or social determinant of health information collected from patients into structural, interoperable data elements using a certified EHR technology.
- Domain 3: Data analysis
  - Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.
- Domain 4: Quality improvement
  - Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
- Domain 5: Leadership engagement
  - Our hospital senior leadership, including chief executives and the entire hospital board of trustees…

- Annually reviews our strategic plan for achieving health equity.
- Annually reviews key performance indicators stratified by demographic and/or social factors.

− Health Equity

Hospital Commitment to Health Equity

Total facility score: 4 out of 5 points

Score	0 of 5	1 of 5	2 of 5	3 of 5	4 of 5	5 of 5
State	1/100 (1%)	0/100 (0%)	2/100 (2%)	2/100 (2%)	11/100 (11%)	85/100 (85%)
National	2/100 (2%)	4/100 (4%)	5/100 (5%)	6/100 (6%)	10/100 (10%)	74/100 (74%)

Domain 1: Equity is a strategic priority	Facility	State	National
Earned Point?	No	92%	87%

Our strategic plan...	Facility	State (% yes)	National (% yes)
...identifies priority populations who currently experience health disparities.	Yes	99%	92%
...identifies healthcare equity goals and discrete action steps to achieving these goals.	Yes	98%	90%
...outlines specific resources which have been dedicated to achieving our equity goals.	Yes	98%	90%
...describes our approach for engaging key stakeholders, such as community-based organizations.	No	92%	89%

+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)

Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6)

Surgical Complications (COMP-HIP-KNEE)

The 30-Day Death Rate measures, also referred to as the 30-Day Risk-Standardized Mortality measures, are typically updated annually during the July public reporting release.

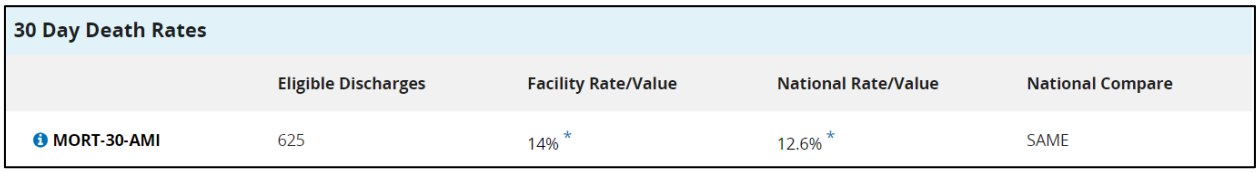
Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

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.

30 Day Death Rate measures display the following data:

- Eligible [Medicare] Discharges
- Facility Rate/Value

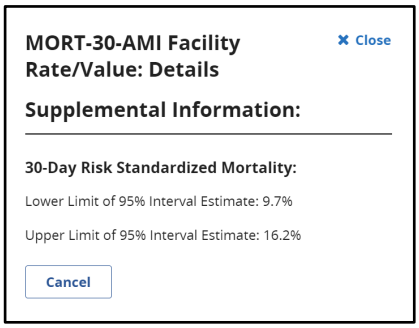
- National Rate/Value
- National Compare



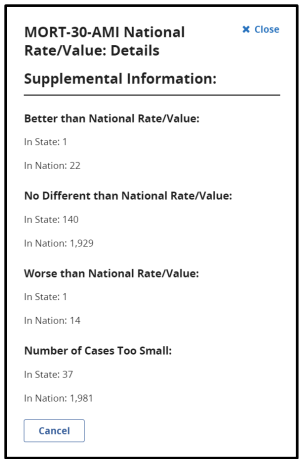
30 Day Death Rates

	Eligible Discharges	Facility Rate/Value	National Rate/Value	National Compare
MORT-30-AMI	625	14% *	12.6% *	SAME

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



State rates do not display for the Mortality measures. However, for each of the measures the national observed result and the number of hospitals in the state and 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.



The HSRs distributed to hospitals via the HQR System provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for all of the mortality and readmission measures. The state and national averages include data from VHA hospitals for these measures:

- EDAC -30-AMI
- EDAC-30-HF
- EDAC-30-PN
- COMP-90-HIPKNEE

- MORT-30-AMI
- MORT-30-HF
- MORT-30-PN
- MORT-30-COPD
- READM-30-AMI
- READM-30-HF
- READM-30-PN
- READM-30-COPD
- READM-30-HOSPWIDE
- READM-30-HIPKNEE

CMS Patient Safety Indicators (PSIs)

Hospitals that participate in the IPPS are included in the calculation of the CMS PSI measures. The following are the CMS PSI measures reported on the Compare tool on Medicare.gov in previous years:

- PSI 04 Death rate among surgical inpatients with serious treatable complications
- CMS PSI 90 Patient safety and adverse events composite

The following indicators are individual components of the CMS PSI 90 measure and are included in the accordion; however, these indicators will only display in the downloadable database on the data catalog on data.cms.gov:

- 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

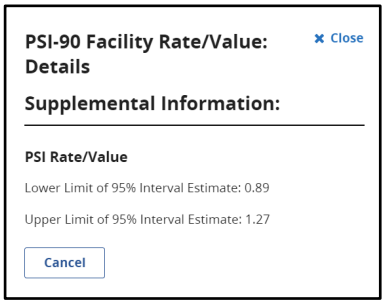
CMS PSIs display the following data:

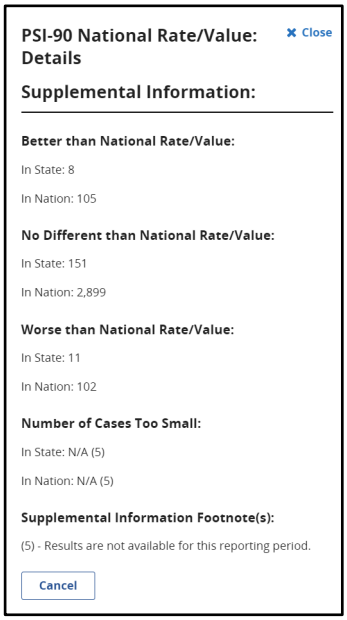
- Eligible [Medicare] Discharges (except for CMS PSI 90)
- Facility Rate/Value (per 1,000 discharges)
- National Rate/Value
- National Compare (comparison to the National Rate/Value)

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/Value	National Rate/Value	National Compare
PSI-3	15,017	0.48 *	0.59 *	SAME
PSI-4	188	193.99 *	166.44 *	SAME
PSI-6	17,916	0.24 *	0.25 *	SAME
PSI-8	18,541	0.10 *	0.09 *	SAME
PSI-9	5,857	2.19 *	2.52 *	SAME
PSI-10	3,320	2.07 *	1.57 *	SAME
PSI-11	3,313	13.94 *	8.86 *	WORSE
PSI-12	6,232	4.08 *	3.63 *	SAME
PSI-13	3,267	4.94 *	5.28 *	SAME
PSI-14	1,263	1.61 *	2.15 *	SAME
PSI-15	3,488	1.14 *	1.10 *	SAME
PSI-90	Not Applicable	1.14 *	1.00 *	SAME

Additional details, including the 95% Confidence Interval Estimates of your Facility's CMS PSI Rate/Value, can be found by selecting the data next to the asterisk in the Facility Rate/Value column.





State rates/values are not displayed for the CMS PSIs. However, for each of the measures, the national Rate/Value and the number of hospitals in the state and the nation in each performance category can be found by selecting the data next to the asterisk in the National Rate/Value column in the accordion. Hospitals' performance is categorized as; Better Than, Same As, Worse Than the National Rate/Value, or Number of Cases Too Small. Number of cases too small is used when there are too few cases (fewer than 25) to reliably tell how well the hospital is performing on an individual CMS PSI measure. For the PSI 90 Composite, the hospital's Comparative Performance rating equal to "N/A" if the hospital had no component measure with at least 25 cases and fewer than 7 component measures with at least 3 cases.

Healthcare-Associated Infections (HAIs)

Hospitals submit HAI data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on the Compare tool on Medicare.gov.

HAI Measure Definitions

HAI-1 — Central Line-associated Bloodstream Infection (CLABSI)

The CLABSI measure includes the number of laboratory-confirmed cases of CLABSI among adult, pediatric, neonatal intensive care unit (ICU), and selected ward patients for events identified within the displayed time frame. Bloodstream infection (BSI) events identified in patients with mucosal barrier injury, extracorporeal life support and Ventricular Assist Device BSI events, Munchausen Syndrome by Proxy, Epidermolysis bullosa, patient self-injection, and pus at vascular access site are excluded.

HAI-2 — Catheter-associated Urinary Tract Infection (CAUTI)

The CAUTI measure includes the number of laboratory-confirmed cases of CAUTI among adult and pediatric ICU and selected ward patients for events identified within the displayed time frame.

HAI-3 — Surgical Site Infections 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.

HAI-4 — 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.

HAI-5 — 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-6 —*Clostridium difficile* (*C. difficile*) Infections

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

HAI Measure Display

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

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

Infections							
	Predicted	Reported	Days / Procedure	Facility Ratio	State Ratio	National Ratio	National Compare
HAI-1	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-2	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-3	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-4	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-5	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-6	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *

Predicted

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

Reported

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

Any data submitted to NHSN after the CMS submission deadline will **not** be included in the data reported for the Preview or on 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 SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections. This procedure count may not match the procedure count shown on NHSN's SIR Report, as NHSN's SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

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/pdfs/ps-analysis-resources/nhsn-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 your hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

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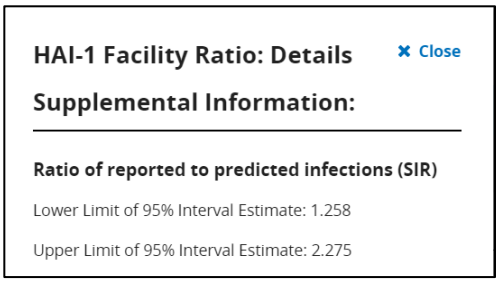
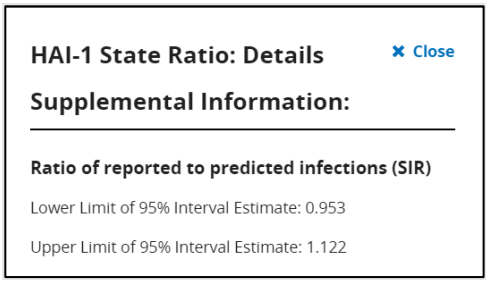
When a hospital's SIR cannot be calculated for a HAI measure because there is less than one predicted infection, or because the hospital's *C. difficile* prevalence rate is above the allowed threshold, the SIR displays "N/A (with Footnote 13)" to indicate the results could not be calculated.

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 your hospital's lower-bound limit and upper-bound limit around the hospital's SIR. The lower- and upper-bound limits of the confidence interval (95%) for your hospital's SIR are an indication of precision and allow interpretation in terms of statistical significance. When the lower limit of the confidence interval cannot be calculated due to the number of observed infections equaling zero, Footnote 8 is applied.





State Ratio

The State Ratio SIR is calculated by dividing the state numerator in scope for quality reporting by the state denominator in scope for quality reporting, for a specific infection type.

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

National Comparison

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

Performance phrases displayed are:

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

Surgical Complications

COMP-HIP-KNEE - RSCR Following Elective Primary THA/TKA surgical complication measure is reported on the Compare tool on Medicare.gov.

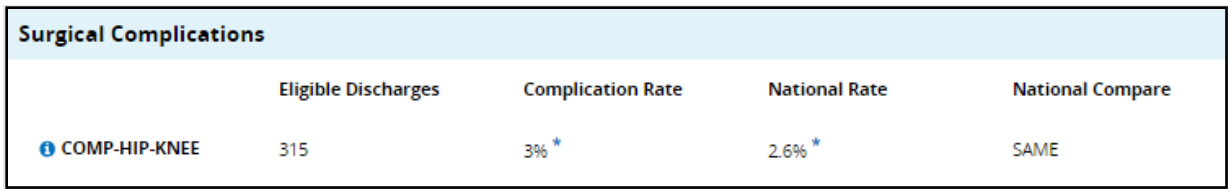
This risk-standardized complication measure is typically updated annually during the public reporting release. The surgical complications portion of the expanded accordion displays the RSCR Following Elective Primary THA and/or TKA measure. This measure is also referred to as the THA/TKA Complication measure.

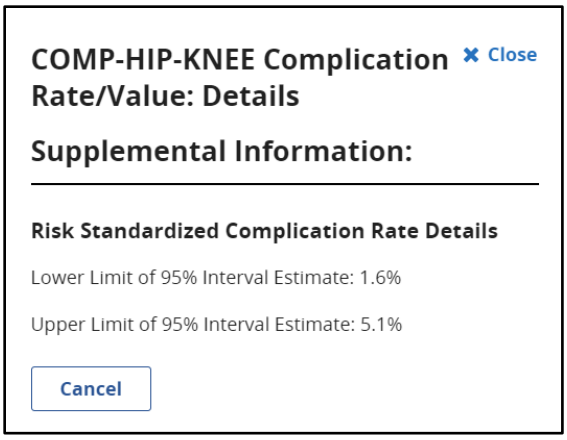
Hospitals are not required to submit these data because CMS calculates the measure from claims and enrollment data.

- The measure is calculated using 33 months of data.
    - The performance period for the THA/TKA Complication measure starts and ends one quarter before the THA/TKA Readmission measure, and the COVID-19 data waiver excludes data from January 1, 2020, to June 30, 2020.
- 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:

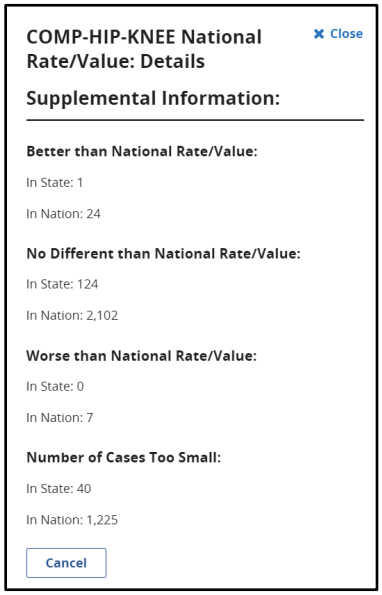
- Eligible [Medicare] Discharges
- Complication Rate/Value
- National Rate/Value
- National Compare





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

State rates do not display for the THA/TKA Complication measure. However, the national observed result and the number of hospitals 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.



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

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.

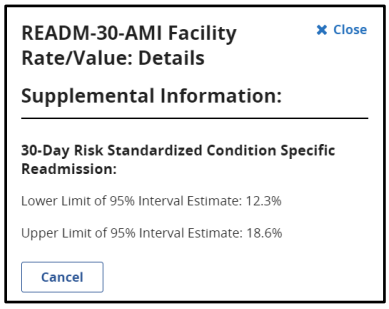
- With the exception of the Hospital-Wide Readmission measure, which is calculated using 12 months of data, the measures are all calculated using 36 months of data.
- Hospitals with fewer than 25 eligible cases for the readmission measures are assigned to a separate category described as "the number 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. As shown in the image below, the readmission measures display:
- Eligible [Medicare] Discharges
- Facility Rate/Value
- National Rate/Value
- National Compare

Unplanned Hospital Visits

Condition Specific Readmission

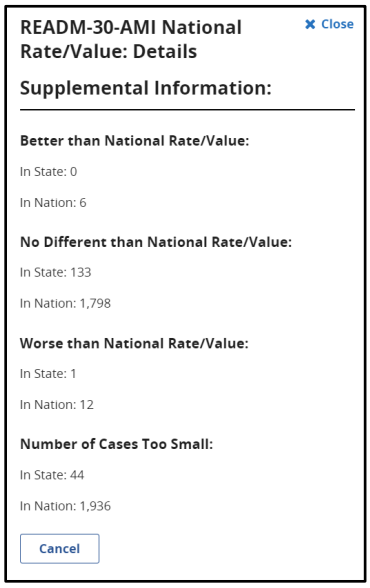
	Eligible Discharges	Facility Rate/Value	National Rate/Value	National Compare
READM-30-AMI	119	15% *	14% *	SAME
READM-30-HF	364	19.8% *	20.2% *	SAME
READM-30-PN	191	17.8% *	16.9% *	SAME
READM-30-COPD	107	21.7% *	19.3% *	SAME

Your 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, for each of the measures, the national observed result and the number of hospitals 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.



Excess Days in Acute Care

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.

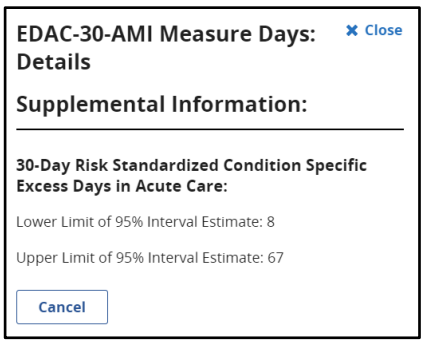
- The measures are calculated using 36 months of data.
- The Compare tool on Medicare.gov will report EDAC as Hospital Return Days measures.
- Hospitals with fewer than 25 eligible cases for the EDAC measures (50 cases for AMI EDAC) are assigned to a separate category described as "the number of cases 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.

EDAC measures display:

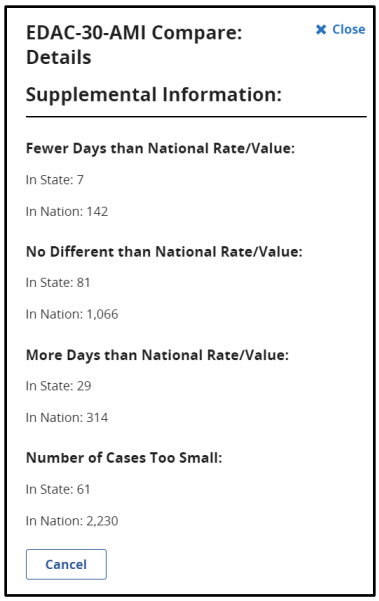
- Eligible [Medicare] Discharges
- Patients Included (number of patients included in the EDAC measure)
- Returning to a Hospital (number of patients who returned to a hospital)
- Measure Days (Your hospital's Excess Days)
- Compare (Your hospital's performance category)

	Eligible Discharges	Patients Included	Returned to a Hospital	Measure Days	Compare
EDAC-30-AMI	798	754	200	-5.9 *	SAME *

Your hospital's 95% Interval Estimates are provided in a modal that can be viewed by selecting the data next to the asterisk in the Measure Days column.



State rates are not calculated for the EDAC measures. However, for each of the measures, the number of hospitals in the state and the nation whose performance was categorized as Fewer Days than Average, Same as National Average Days, More Days than Average, or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the Compare column. The national averages include data from VHA hospitals.



+Payment & Value of Care

Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE)
Medicare Spending per Beneficiary (MSPB-1)

Medicare Payment Measure

The results for the Medicare condition- and procedure-specific payment measures are typically updated annually during the July public reporting release. Hospitals are not required to submit payment measure data because CMS calculates the measure from claims and enrollment data.

- Measure results are calculated using 36 months of data for AMI, HF, and Pneumonia payment. THA/TKA payment results are calculated using 33 months of data.
- Hospitals with fewer than 25 eligible cases for the payment measures are assigned to a separate category described as “the number of cases is too small (fewer than 25) to reliably

estimate the hospital's Risk-Standardized Payment (RSP)." Those hospitals are included in the measure calculation but will not be reported on the Compare tool on Medicare.gov.

- These measures are hospital-level measures of payments for an episode of care that begins with an inpatient admission for the condition or procedure of interest and ends either 30 days for AMI, HF, and Pneumonia or 90 days for THA/TKA post-admission.
- These payment measures calculate RSPs, which add up payments for patients across multiple care settings, services, and supplies (i.e., inpatient, outpatient, skilled nursing facility, home health agency, hospice, physician/clinical laboratory/ambulance services, durable medical equipment, prosthetics/orthotics, and supplies) during the designated episode of care.
- While these payment measures only include Medicare fee-for-service beneficiaries, they capture payments made by Medicare, other health insurers, and the patients themselves.

Many of the specifications of these payment measures were closely aligned with the specifications of the corresponding mortality measures for AMI, HF, and Pneumonia.

The THA/TKA payment measure aligns with the corresponding surgical complication measure.

The payment measures risk-adjust for patient age and comorbid conditions. These measures also remove differences due to geographic variation or policy adjustments. A lower or higher RSP does not, by itself, imply that a hospital is providing better care. As the AMI, HF, and Pneumonia payment measure specifications align with those of the mortality measures, and, as the THA/TKA payment measure specifications align with those of the surgical complication measure, RSPs for AMI, HF, Pneumonia, or THA/TKA should be considered alongside hospital performance on the corresponding outcome measure for that condition or procedure.

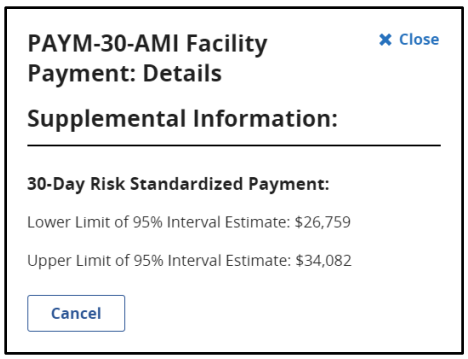
Payment measure display:

- Eligible [Medicare] Discharges
- Facility Payment
- National Average Payment
- National Compare

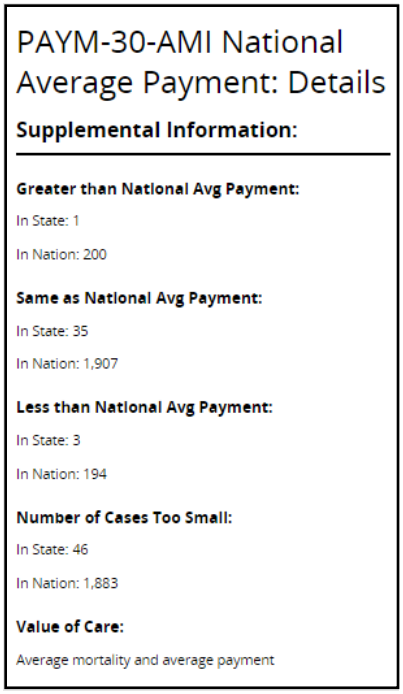
Payment

	Eligible Discharges	Facility Payment	National Average Payment	National Compare
PAYM-30-AMI	715	$23,394 *	$23,745 *	SAME
PAYM-30-HF	813	$17,041 *	$16,632 *	SAME
PAYM-30-PN	534	$18,281 *	$17,415 *	SAME
PAYM-90-HIP-KNEE	310	$25,812 *	$21,953 *	WORSE

The Preview UI will display the Eligible Discharges, Facility Payment, National Average Payment, and National Compare payment category (Greater than, Same as, or Less than the National Average Payment) for each measure. The 95% Interval Estimates can be viewed by selecting the data next to the asterisk in the Facility Payment column.



State payment averages are not calculated for the payment measures. However, for each of the measures, the national average payment and the number of hospitals in the state and the nation whose performance was categorized as Greater than National Avg Payment, Same as National Avg Payment, Less than National Avg Payment, or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the National Average Payment column.



The Value of Care category displays the mortality/complication and payment values for each hospital and can be found in the National Average Payment Detail Modal.

Medicare Spending per Beneficiary

The Medicare Spending per Beneficiary (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.

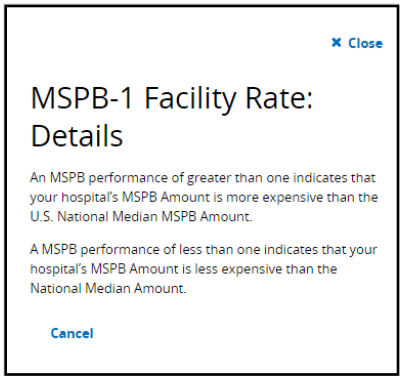
The results for the MSPB measure will be updated annually during the public reporting release on the Compare tool on Medicare.gov. Hospitals are not required to submit data for the measure because CMS calculates the measure from claims and enrollment data.

Note: CMS adopted a re-evaluated version of the MSPB measure for the Hospital IQR Program beginning with FY 2024 and publicly reported data for the first time in the January public reporting release. CMS will continue to use the MSPB measure data displayed on the October 2023 preview report and the same results displayed on the Compare tool on Medicare.gov in January 2023 to compute MSPB results for the Hospital VBP Program. This calculation will use the existing version of the measure specifications until the re-evaluated measure is adopted by the Hospital VBP Program through rulemaking.

- Measure results are calculated using one year of data.
- A performance of greater than one indicates that your hospital's MSPB Amount is more expensive than the U.S. National Median Amount.
- A performance of less than one indicates that your hospital's MSPB Amount is less expensive than the U.S. National Median Amount.
- Your hospital's MSPB performance is the ratio of your hospital's price-standardized, risk-adjusted MSPB Amount to the episode-weighted median MSPB Amount across all hospitals.

MSPB measure will display:

- Facility Rate/Value
- State Rate/Value
- National Rate/Value
- National Median Amount



Medicare Spending per Beneficiary

	Facility Rate	State Rate	National Rate	National Median Amount
MSPB-1	0.98 *	1.01	0.99	$24,299.69

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

THA/TKA Pre-operative Surveys only (Voluntary)

The Centers for Medicare & Medicaid Services (CMS) has adopted the total hip arthroplasty/total knee arthroplasty (THA/TKA) patient-reported outcome-based performance measure (PRO-PM) for use in the Hospital Inpatient Quality Reporting (IQR) program beginning with Fiscal Year (FY) 2028 payment determination.

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.

The purpose of Voluntary Reporting is to familiarize hospitals with the measure in advance of Public Reporting and payment determination. The Voluntary Reporting periods will provide hospitals with an opportunity to:

- Ask questions and test PRO data submission to CMS before Mandatory Reporting.
- Receive confidential feedback reports that include their PRO data response rates and measure results prior to Mandatory Reporting of measure results.
- Review the data used to calculate their THA/TKA PRO-PM results.
- Get information on how to interpret their measure results.
- Ask questions about and provide feedback on the measure.

The pre-operative assessment response rate for hip/knee replacement patients preview report will display the following:

- Completed surveys
- Eligible patients
- Response rate

Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Measure	Completed Surveys	Eligible Patients	Response Rate
THA/TKA Inpatient Pre-operative surveys only (Voluntary)	95	100	95%

Note: Providers who have voluntarily submitted surveys will be listed on the Compare tool on Medicare.gov as participating and their response rate will also be displayed.

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.

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. The option to request withholding of data from the Compare tool on Medicare.gov is only available during the 30-day preview period.

Withholding Overview

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

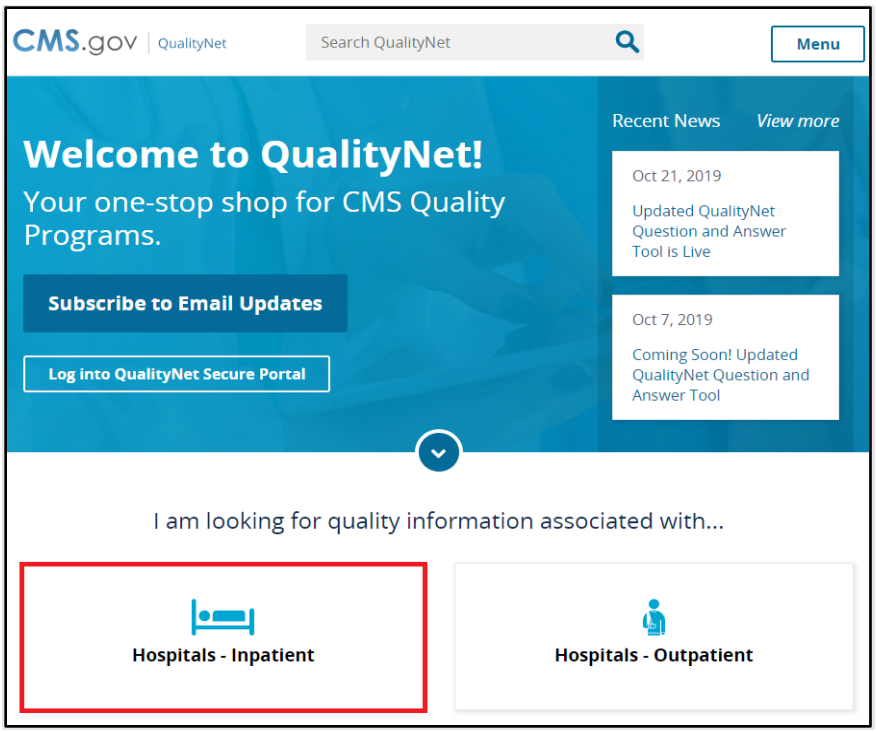
Hospitals that do not have an appropriate Notice of Participation, or pledge, display only the CCN, hospital name and the following message: "You do not have an Inpatient Notice of Participation to publicly report data for the Preview period."

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 8 a.m. to 8 p.m. Eastern Time.

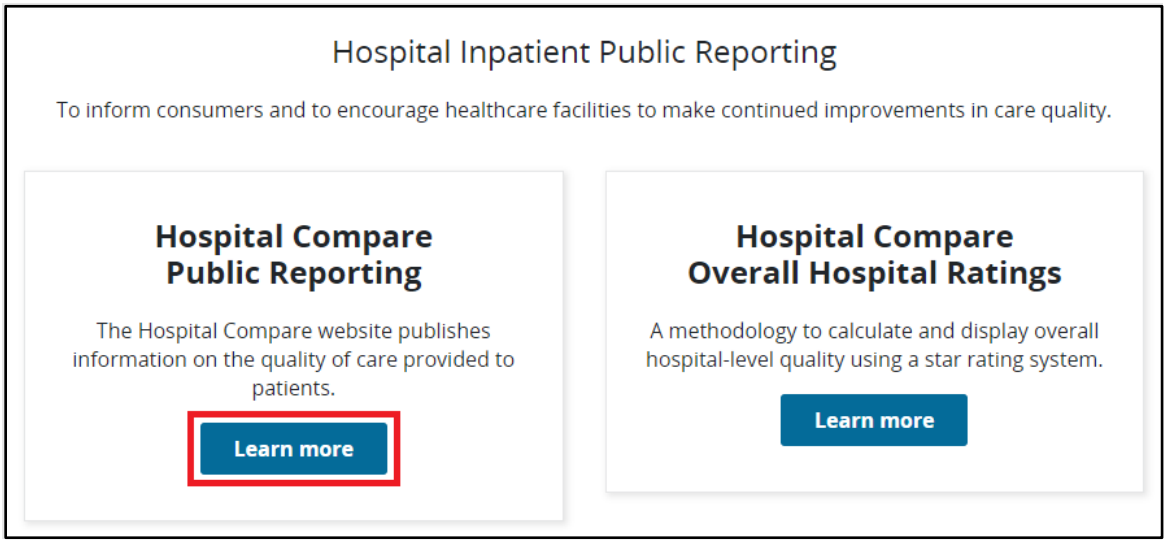
Procedure to Withhold Data

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 Hospital 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 release.

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 Unplanned Hospital Visits Continued	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 (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-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 its Preview UI, but not on the Compare tool on Medicare.gov.)

Number	Description	Application
6	Fewer than 100 patients completed the HCAHPS survey (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS surveys is 50–99.
7	No cases met the criteria for this measure	Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
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.
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

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.	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 • 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.

Number	Description	Application
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. 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 your questions relate. Do NOT submit patient-identifiable information (e.g., 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 CCSQ 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 your specific topic.

CMS PSI Measures

For questions regarding the CMS PSIs, refer to CMS Patient Safety Indicators Version 14.0 Fact Sheet (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

Please 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

Please contact the:

- 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

- Payment Measures Implementation Team at QualityNet Question and Answer Tool Program: Inpatient Claims-Based Measures > Payment (AMI, Heart Failure, Pneumonia, Hip/Knee) > Understanding Measure Methodology

TKA/TKA PRO-PM Measure

Please contact the TKA/TKA PRO-PM Implementation Team at QualityNet Question and Answer Tool > Program: Inpatient Claims-Based Measures > Hip/Knee PRO-PM > Understanding Measure Methodology

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 your specific Topic. This will get your inquiry directly to the Overall Star Ratings inbox.

Sepsis Measures

Please contact the Sepsis Team via the QualityNet Question and Answer Tool.