# Compare Tool on Medicare.gov Preview Help Guide

## February 2025 Public Reporting Preview/ April 2025 Public Reporting Release

## Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Facilities participating in the IPFQR Program are the primary audience for this publication. The document's scope is limited to providing instructions for those facilities to access and interpret the data provided on the public reporting user interface prior to the publication of data on the Compare tool on Medicare.gov.

The Centers for Medicare & Medicaid Services (CMS) will not use data reflecting services provided January 1, 2020–June 30, 2020 (Quarter (Q)1 2020 and Q2 2020) in its calculations for Medicare quality reporting.

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

CMS will apply a new footnote to the measure data identified by those providers. See the Footnote section of this guide for more information.

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# Preview Help Guide: IPFQR Program

## Overview

The Compare tool on Medicare.gov has information about the quality of care at more than 4,000 hospitals and facilities across the country. It uses information from providers that receive Medicare and Medicaid payments and participate in one or more of the various quality reporting programs. Along with some contextual information about the Compare tool on Medicare.gov and *QualityNet*, this help guide focuses on accessing the Preview for the IPFQR Program.

Section 1886(s)(4)(E) of the Social Security Act established procedures for making the IPFQR Program data available to the public. Inpatient psychiatric facilities (IPFs) have the opportunity to review the data that will be made public. For each payment determination year, the submitted data will be publicly displayed.

Facilities are provided the opportunity to review data published on the Compare tool on Medicare.gov. Preview data is made available for facilities participating in the IPFQR Program during a 30-day preview period. The purpose of this review is to preview the data that will be published on the Compare tool on Medicare.gov and not for data correction. Facilities are only able to make changes to their data prior to the submission deadline.

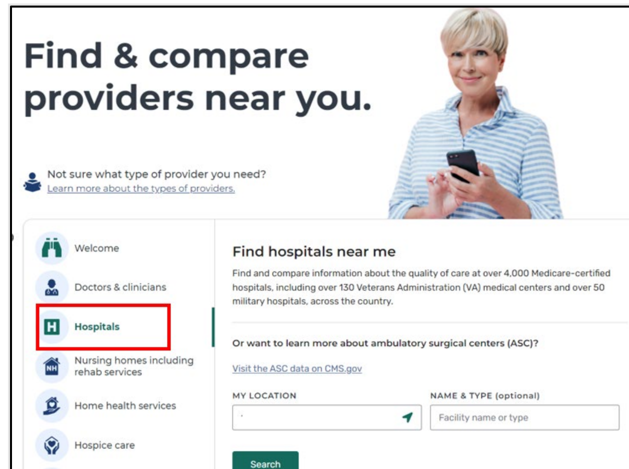
## The Compare Tool on Medicare.gov

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.

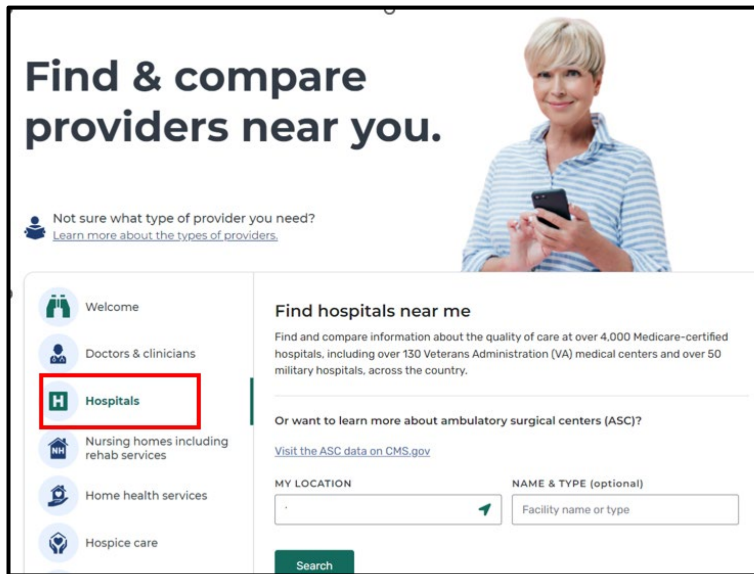
## Navigating to the Data Catalog on data.cms.gov

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

## Compare Tool on Medicare.gov

To navigate to the Compare tool on Medicare.gov:

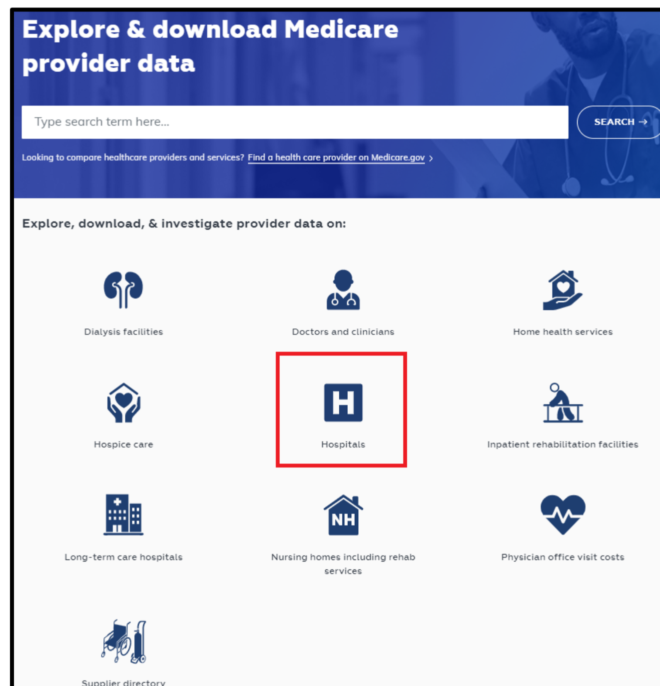
4. From the left column of the home page, select Hospital.



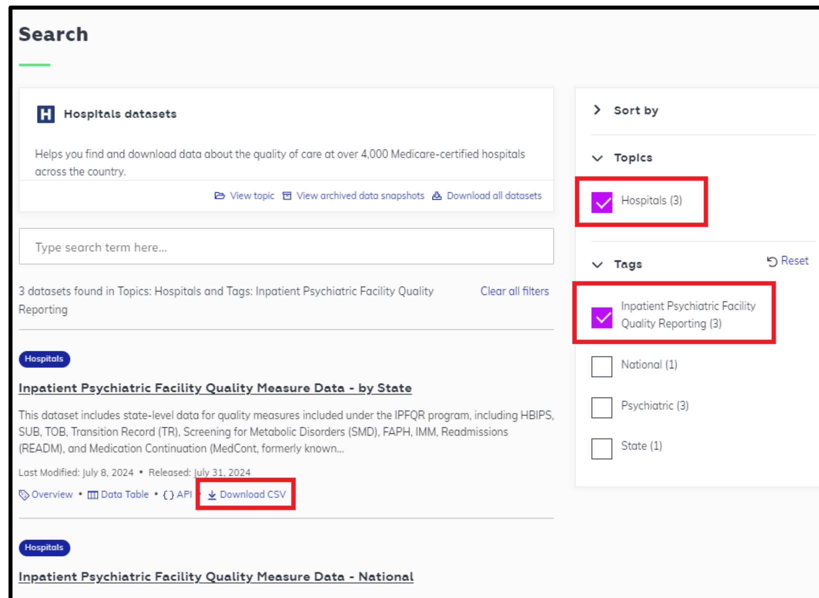

5. On the home page, you may enter your ZIP code. Select Search.
6. Select up to three providers from the list to view the data.

## Data Catalog on Data.cms.gov

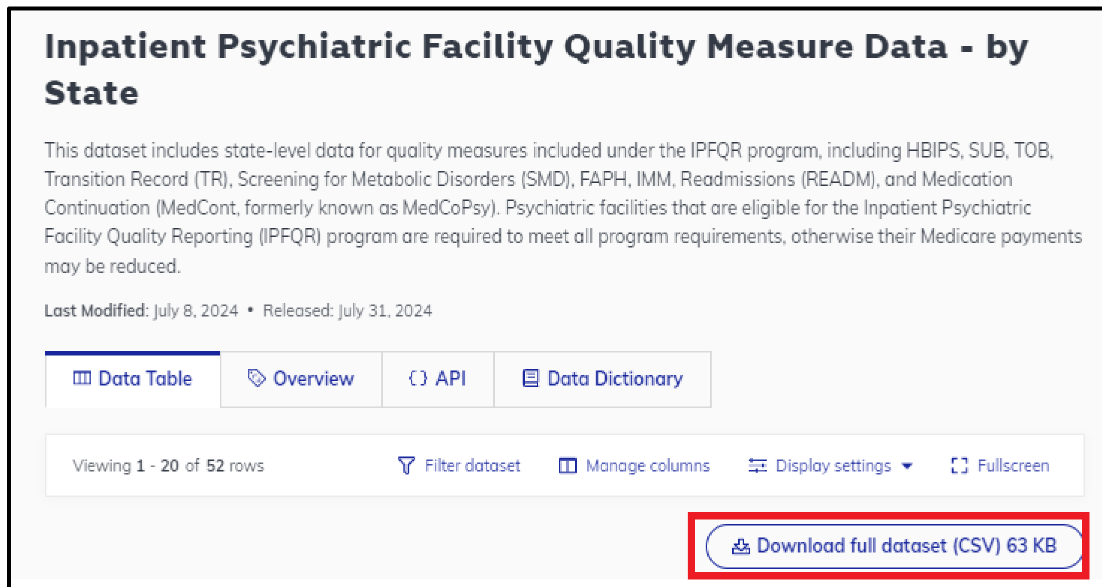
4. Navigate to the data catalog at https://data.cms.gov/provider-data/. Select Hospitals on the home page.




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




6. Users can download the dataset easily into a CSV file. By selecting the dataset's title, the user is directed to the specific dataset page where publicly displayed data on the Dataset explorer can be viewed.




7. On the **View Topic Details** page, users are able to view and download archived dataset data. Users can also gather additional information and background regarding the data.

## Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

The IPFQR Program is a pay-for-reporting program established under section 1886(s)(4) of the Social Security Act. To meet the program requirements, IPFs are required to submit all quality measures in the

form, manner, and time as specified by the Secretary, to CMS, beginning with fiscal year 2014 payment determination year and subsequent fiscal years. Eligible IPFs that do not participate in the IPFQR Program in a fiscal year or do not meet all of the reporting requirements will receive a 2.0-percentage point reduction of their annual payment update under the Inpatient Psychiatric Facilities Prospective Payment System. The reduction is non-cumulative across payment years.

The IPFQR Program was developed as mandated by section 1886(s)(4) of the Social Security Act. The IPFQR pay-for-reporting program is intended to equip consumers with quality-of-care information to make more informed decisions about healthcare options. It is also intended to encourage facilities and clinicians to improve the quality of inpatient care provided to beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

To meet the IPFQR Program requirements, IPFs are required to submit all quality measures in the form, manner, and time as specified by the Secretary, to CMS, beginning with fiscal year 2014 payment determination year and subsequent fiscal years. Because this is a pay-for-reporting program, eligible facilities will be subject to payment reduction for non-participation.

Eligible IPFs that do not participate in the IPFQR Program in a fiscal year or do not meet all of the reporting requirements will receive a 2.0-percentage point reduction of their annual payment update. The reduction is non-cumulative across payment years.

## Preview Period

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

## Public Reporting User Interface (UI)

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

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

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

Follow the instructions below to access the Preview UI:

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

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

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

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

7. Your provider name will appear at the top of the Preview UI. The **Change Organization Button** is available to users with roles associated with multiple facilities to see a different provider's data.
8. There are three tabs: **Measure Data**, **Star Rating** and **Promoting Interoperability Program**.

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

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

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

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

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

## PR Data Details

### Facility Characteristics

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

Type of ownership is publicly available only in the downloadable database on the data catalog 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.)

## IPFQR Preview Details

### Measure Data Tab

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

Search
Release October 2022
Level Select
Performance Select
Clear Filters
+ Timely and Effective Care
+ Unplanned Hospital Visits
+ Follow-Up Care
+ Substance Use Treatment
+ Patient Safety
+ Preventive Care and Screening

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

**– Substance Use Treatment**

**Substance Use**

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| SUB-2 | 62% | 700 | 43% * | 52% * | 26% |
| SUB-2a | 42% | 900 | 53% * | 82% * | 54% |
| SUB-3 | 62% | 700 | 43% * | 52% * | 26% |
| SUB-3a | 22% | 9600 | 13% * | 32% * | 26% |

**Tobacco Use**

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| TOB-2 | 62% | 700 | 43% * | 52% * | 26% |
| TOB-2a | 29% | 900 | 33% * | 32% * | 15% |
| TOB-3 | 22% | 9600 | 13% * | 32% * | 26% |
| TOB-3a | 92% | 600 | 43% * | 23% * | 30% |

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

✖ Close

SUB-2: Details

**Description:**

Alcohol Use Brief Intervention Provided or Offered

**Reporting Period:**

Q1 (2016) - Q2 (2016)

Cancel

Data will 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).

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| SUB-2 | 62% | 700 | 43% * | 52% * | 26% |

✖ Close

SUB-2 State Rate: Details

**Footnote(s):**

( 4 ) - Data suppressed by CMS for one or more quarters.

Cancel

✖ Close

SUB-2 National Rate: Details

**Footnote(s):**

( 7 ) - No cases met the criteria for this measure.

Cancel

## Timely and Effective Care Measure

| + Timely and Effective Care |
| --- |
| COVID-19 Vaccination Coverage Among Healthcare Personnel (IPFQR-HCP COVID-19) |

### COVID-19 Vaccination Coverage Among Healthcare Personnel (IPFQR-HCP COVID-19)

COVID-19 Vaccination Among Healthcare Personnel (HCP COVID-19) reflects data provided by the Centers for Disease Control and Prevention (CDC) for public reporting. Each quarter, CDC will calculate quarterly HCP COVID-19 vaccination coverage rates for each facility by taking the average of the data from three weekly rates submitted by the facility for that quarter. For facilities that report more than one week per month, the last week of the reporting month will be used. The data will reflect a single quarter of data in each quarterly release. They were first reported for the October 2022 public reporting release, reflecting Q4 2021 data. 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, providers 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.

IPFQR-HCP COVID-19 measure displays the following data:

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

| Healthcare Personnel Vaccination | | | |
| --- | --- | --- | --- |
| | Facility's Adherence Rate | State Adherence Rate | National Adherence Rate |
| IPFQR-HCP_COVID-19 | 6.9% | 11.4% | 18.1% |

### Facility's Adherence Rate

The COVID-19 HCP 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 have worked at the healthcare facility for at least one day during the reporting week of data collection period regardless of clinical responsibility or patient contact.

### State Adherence Rate

State Adherence Rates are calculated as the total number of healthcare personnel in the state contributing to successful vaccination adherence divided by the total number of healthcare personnel in the state. For the COVID-19 HCP 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 COVID-19 HCP Vaccination National Adherence Rate, the denominator excludes HCP for whom COVID-19 vaccination was contraindicated per CDC's NHSN data collection instructions.

## Unplanned Hospital Visits Measure

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

### Inpatient Psychiatric Facility Readmission

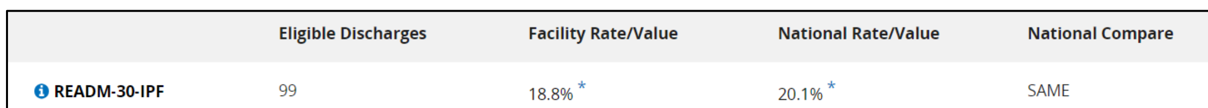
The Inpatient Psychiatric Facility Readmission section includes READM-30-IPF (Rate of readmission after discharge from hospital). Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data using 24 months of data.

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

#### MEASURE DETAILS

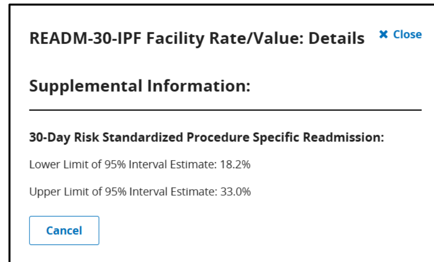
The measure will display the following data:

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

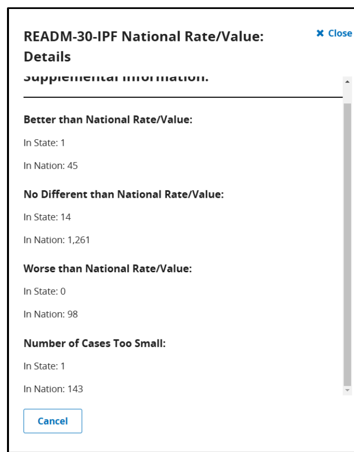


| | Eligible Discharges | Facility Rate/Value | National Rate/Value | National Compare |
|---|---|---|---|---|
| READM-30-IPF | 99 | 18.8% * | 20.1% * | SAME |

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, 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.




## Follow-Up Care Measures

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

### Transition Record

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

### Measure Details

The TR-1 measure will display the following data:

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

- Top 10%

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| TR1 | 94% | 162 | 48% | 50% | 98% |

### 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.

## Follow-Up After Psychiatric Hospitalization (FAPH)

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

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

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

## Measure Details

The measures display the following data:

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

| Follow-up After Psychiatric Hospitalization | | | | | |
|---|---|---|---|---|---|
| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
| FAPH-7 | 45.8% | 24 | 42.8% | 36.2% | 54% |
| FAPH-30 | 79.2% | 24 | 70.1% | 60% | 77.9% |

### 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.

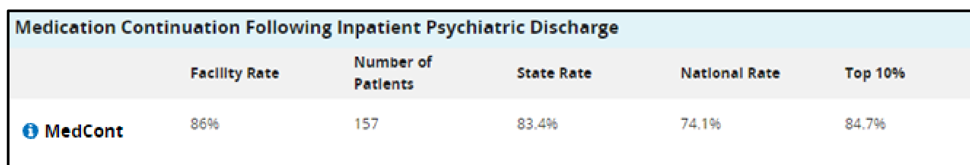
## Medication Continuation Following Inpatient Psychiatric Discharge

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

## Measure Details

The measures display the following data:

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



Medication Continuation Following Inpatient Psychiatric Discharge

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| MedCont | 86% | 157 | 83.4% | 74.1% | 84.7% |

### 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.

## Substance Use Treatment Measures

| + Substance Use Treatment |
| --- |
| Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a)<br>Tobacco Use (TOB-3, TOB-3a) |

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

This section contains the following measures:

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

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

This section contains the following measures:

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

### Measure Details for the Substance Use and Tobacco Use Measures

These measures display the following data:

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

| − Substance Use Treatment | | | | | |
|---|---|---|---|---|---|
| **Substance Use** | | | | | |
| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
| SUB-2 | 1% | 490 | 64% | 58% | 100% |
| SUB-2a | 19% | 32 | 77% | 76% | 100% |
| SUB-3 | 13% | 161 | 65% | 71% | 100% |
| SUB-3a | 12% | 161 | 60% | 59% | 99% |
| **Tobacco Use** | | | | | |
| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
| TOB-3 | 1% | 154 | 61% | 57% | 97% |
| TOB-3a | 1% | 154 | 14% | 16% | 80% |

### State Rate

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

### National Rate

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

### Top 10%

The 90$^{th}$ percentiles are calculated for each measure using the un-weighted average or median for each eligible hospital and identifying the top 10% of hospitals.

## Patient Safety Measures

| + Patient Safety |
|---|
| Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3) |

## HBIPS Measures

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

This section includes the following measures:

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

## Measure Details

The measures display the following data:

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

| | Facility Rate | State Rate | National Rate |
|---|---|---|---|
| HBIPS-2 | 0.92 * | 0.43 * | 0.23 * |
| HBIPS-3 | 0.72 * | 0.83 * | 0.93 * |

### State Rate

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

### National Rate

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

### Top 10%

The 90$^{th}$ percentiles are calculated for each measure using the un-weighted average or median for each eligible hospital and identifying the top 10% of hospitals.

## Preventative Care and Screening Measures

| + Preventative Care and Screening |
|---|
| Screening (SMD)<br>Immunization (IMM-2) |

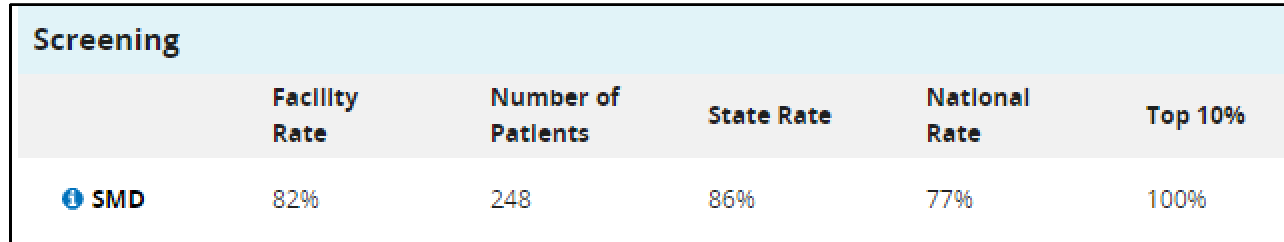
## Measure Details for the Preventative Care and Screening Measure

The measures display the following data:

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

## Screening Measure

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



**Screening**

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| SMD | 82% | 248 | 86% | 77% | 100% |

### State Rate

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

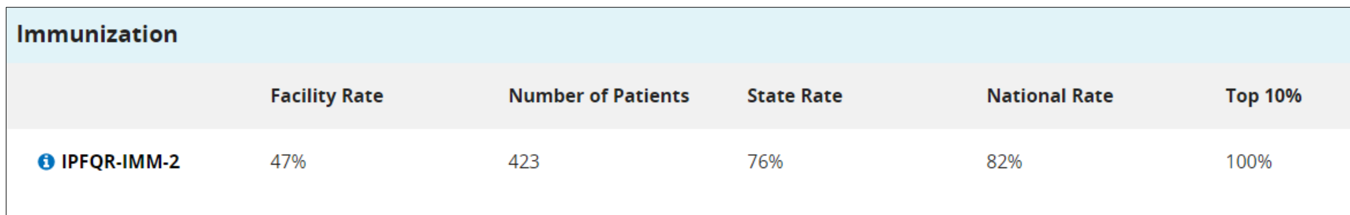
### National Rate

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

### Top 10%

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

## Immunization (IMM-2)



**Immunization**

| | Facility Rate | Number of Patients | State Rate | National Rate | Top 10% |
|---|---|---|---|---|---|
| IPFQR-IMM-2 | 47% | 423 | 76% | 82% | 100% |

The aggregate rate for the IMM-2 measure includes data collected only during the influenza season quarters. Data displayed are for the 2023/2024 influenza season, Q4 2023–Q1 2024.

## State and National Rates

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

### Top 10%

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

# 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)<br>HCAHPS Summary Star Ratings<br>Communication with Nurses<br>Communication with Doctors<br>Responsiveness of Hospital Staff<br>Communication About Medicines<br>Cleanliness of Hospital Environment<br>Quietness of Hospital Environment<br>Discharge Information<br>Care Transition<br>Hospital Rating<br>Recommend this Hospital |
| Timely and Effective Care | Sepsis<br>(SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR)<br>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)<br>Cardiac Care (OP-40)<br>Cataract (OP-31)<br>Colonoscopy (OP-29)<br>Opioid Use (Safe Use of Opioids-Concurrent Prescribing)<br>Venous Thromboembolism (VTE-1, VTE-2)<br>Stroke Care (STK-02, STK-03, STK-05, STK-06)<br>Hospital Harm (HH-01, HH-02) |
| Maternal Health | Maternal Morbidity Structural Measure (SM-7)<br>Perinatal Care (ePC-02, PC-05, ePC-07a, ePC-07b) |
| Health Equity | Hospital Commitment to Health Equity (HCHE) |

| Measure Accordion | Measure IDs Included |
|---|---|
| Complications & Deaths | 30-Day Death Rates (MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG)<br>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)<br>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)<br>Surgical Complications (COMP-HIP-KNEE)<br>Surgical Treatment Complications (PCH-37) |
| Unplanned Hospital Visits | Condition Specific Readmission (READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD)<br>Procedure Specific Readmission (READM-30-CABG, READM-30-HIP-KNEE)<br>Hospital Wide Readmission (READM-30-HOSPWIDE)<br>Inpatient Psychiatric Facility Readmission (READM-30-IPF)<br>Procedure Specific Outcomes (PCH-30, PCH-31, OP-32, OP-35 ADM, OP-35 ED, OP-36)<br>Readmission Measure (PCH-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)<br>Medicare Spending per Beneficiary (MSPB-1) |
| Follow-Up Care | Transition Record (TR1)<br>Follow-Up After Psychiatric Hospitalization (FAPH-7, FAPH-30)<br>Medication Continuation Following Inpatient Psychiatric Discharge (MedCont) |
| Substance Use Treatment | Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a)<br>Tobacco Use (TOB-3, TOB-3a) |
| Patient Safety | Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3) |
| Preventative Care and Screening | Screening (SMD)<br>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.<br>For HCAHPS:<br>• This is applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges.<br>• HCAHPS scores based on fewer than 25 completed surveys will display on the Preview UI.<br>• Data will not display on the Compare tool on Medicare.gov.<br>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.<br><br>For HCAHPS:<br>• When a hospital did not participate in HCAHPS reporting during the period covered by the applicable Preview UI<br>• When a hospital only participated in HCAHPS reporting for a portion of the period covered by the applicable Preview UI<br>• When a hospital chooses to suppress HCAHPS results (A hospital will see HCAHPS results on |

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

| Number | Description | Application |
| --- | --- | --- |
| 12 | This measure does not apply to this hospital for this reporting period | Applied to the measure when either the hospital has a waiver, or the hospital submitted to NHSN:<br>• Zero Central Line Days<br>• Zero Catheter Days<br>• Zero Surgical Procedures |
| 13 | Results cannot be calculated for this reporting period | Applied to emergency department measures when the average minutes cannot be calculated for a volume category.<br><br>For HAI measures:<br>Applied when the hospital's SIR cannot be calculated because:<br>• The number of predicted infections is less than one.<br>• The C. difficile prevalence rate is greater than the established threshold.<br>Note: The number of predicted infections will not be calculated for those facilities with an outlier C. difficile prevalence rate.<br><br>Applied when the provider was excluded from the measure calculation as a non-IPPS hospital.<br><br>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:<br>• Reported data for fewer than three measures in any measure group used to calculate overall ratings or |

| Number | Description | Application |
| --- | --- | --- |
| | | • Reported data for fewer than three of the measure groups used to calculate ratings or<br>• Did not report data for at least one outcomes measure group. |
| 17 | This hospital's overall rating only includes data reported on inpatient services. | This footnote is applied when a hospital only reports data for inpatient hospital services. |
| 22 | Overall star ratings are not calculated for the Department of Defense (DoD) hospitals. | DoD hospitals are not included in the calculations of the overall star ratings. |
| 23 | The data are based on claims that the hospital or facility submitted to CMS. The hospital or facility has reported discrepancies in their claims data. | This footnote is applied when a hospital or facility alerts CMS of a possible issue with the claims data used to calculate results for this measure.<br>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. |

| Number | Description | Application |
|---|---|---|
| 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.<br><br>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 regarding the IPFQR Program Preview or the IPFQR Program may be directed to the IPFQR Program Support Contractor via the QualityNet Question and Answer Tool or by calling (866) 800-8765, Monday to Friday, 8 a.m. to 8 p.m. Eastern Time.