Medicare Promoting Interoperability Program Public Reporting Preview Help Guide

October 2024 Public Reporting Preview/January 2025 Public Reporting Release of CY 2023 data

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

Table of Contents

Overview

Care Compare on Medicare.gov

CMS and the nation's hospitals work collaboratively to publicly report hospital quality performance information on Care Compare on Medicare.gov and the data catalog on data.cms.gov.

Care Compare 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. Eligible hospitals and CAHs are considered Meaningful Users of CEHRT and could receive a down payment if they did not: score a minimum of 60 points on objectives and measures, report on eCQMs, meet additional requirements of the Medicare Promoting Interoperability Program.

In alignment with the Hospital IQR Program, the Medicare Promoting Interoperability Program (85 FR 58975) finalized the public reporting of eCQM data submitted by hospitals.

In the FY 2023 IPPS/LTCH PPS final rule, CMS finalized the proposed public reporting of the Medicare Promoting Interoperability Program data beginning with the calendar year (CY) 2023 EHR reporting period.

About the Medicare Promoting Interoperability Program

The Centers for Medicare and Medicaid Services (CMS) established the Electronic Health Record (EHR) Incentive Programs to encourage eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of CEHRT.

To continue a commitment to promoting and prioritizing interoperability and exchange of health care data, CMS renamed the EHR Incentive Programs to the Medicare Promoting Interoperability Programs in April 2018. This change moved the programs beyond the existing requirements of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving patient access to health information.

To navigate to [Care Compare on Medicare.gov:](#)

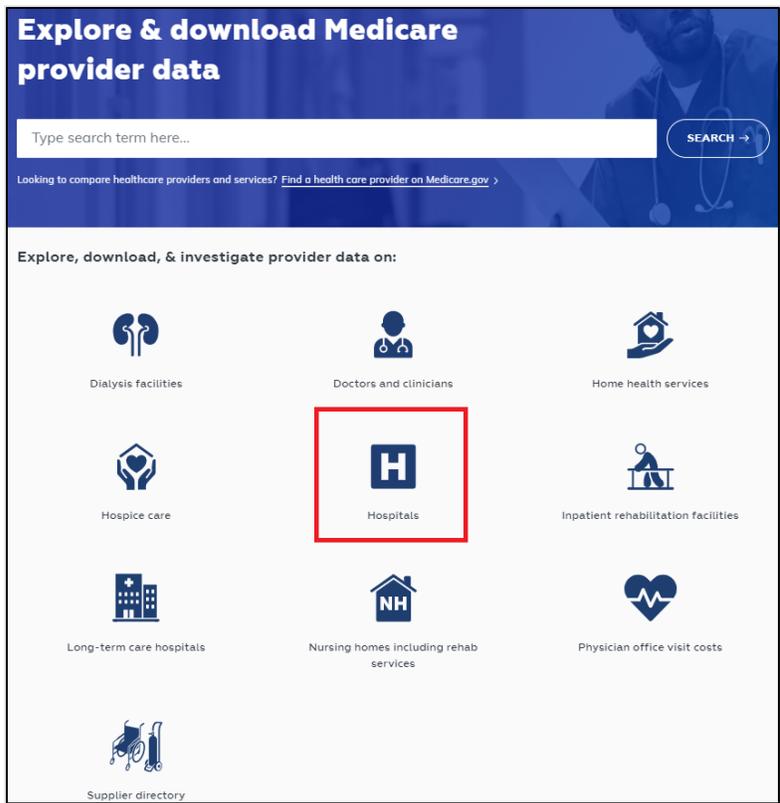1. From the left column of the home page, select **Hospitals**.
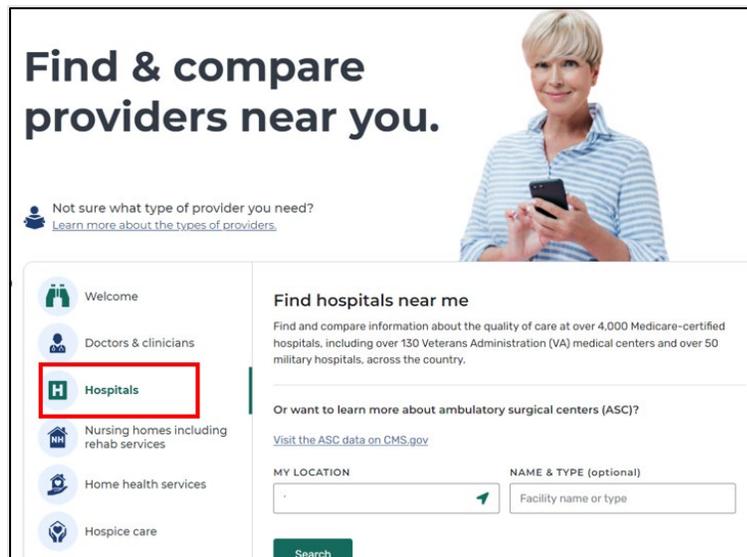
2. On the home page, you may enter your ZIP code. Select **Search**.

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. 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.
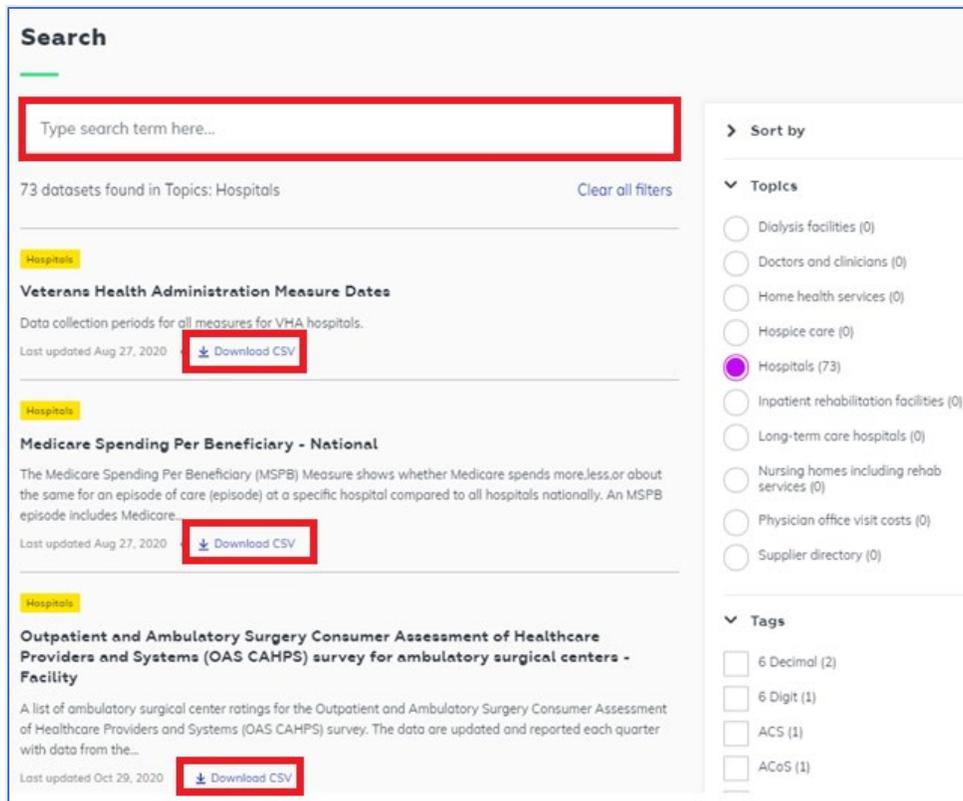
3. Users can download the dataset easily into a CSV file. By selecting the dataset's title, the user is directed to the specific dataset page where publicly displayed data on the Dataset explorer can be viewed.
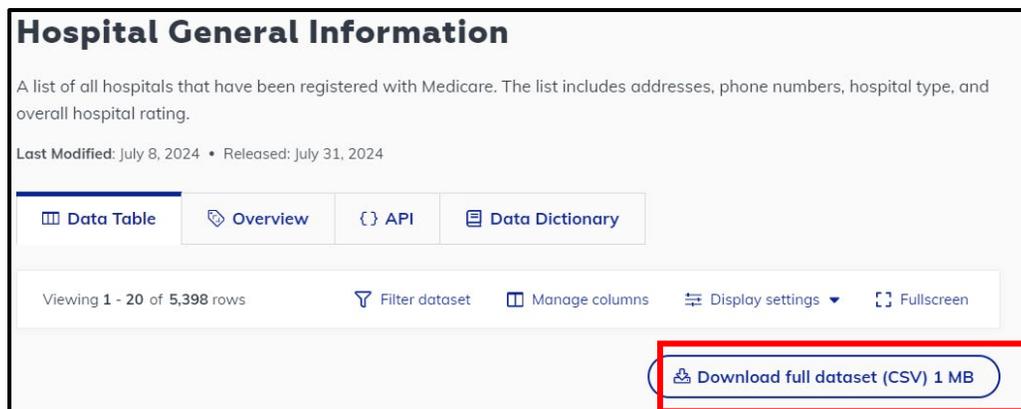
4. On the **View Topic Details** page, users can view and download archived dataset data. Users can also gather additional information and background regarding the data.

Preview Period

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

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 Care Compare on Medicare.gov.

Users must have a Health Care Quality Information Systems Access Roles and Profile (HARP) account to access the Preview UI. If you do NOT have a HARP account please sign into the HQR system at https://qualitynet.cms.gov/ to create one.

CMS announced that, beginning on May 11, 2022, the HQR system no longer supports the use of Internet Explorer. To avoid technical issues when logging into the HQR system, use either Google Chrome or Microsoft Edge.

Follow the instructions below to access the 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.** Then, select **Next**.

4. Once you receive the code via **Text** or **Email**, enter it. Then, select **Next**.
5. On the **HQR** system landing page, hover over 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.
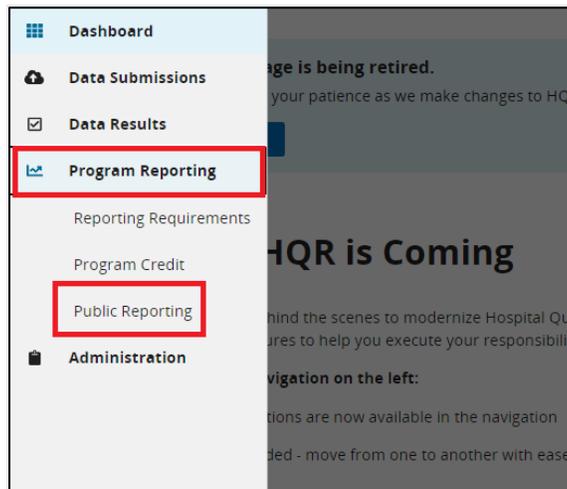
7. Your provider name will appear at the top of the Preview UI. The **Change Organization Button** is available to users with roles associated with multiple facilities to see a different provider's data.
8. There are three tabs: Measure Data, Star Rating and Promoting Interoperability Program.

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.

Data Details

Hospital Characteristics

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

Type of ownership is publicly available only in the downloadable database on the Provider Data Catalog found on data.cms.gov

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. 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.)

Promoting Interoperability Program Tab

The preview UI displays these results:

Facility Score.

- Objective Scores must add up to at least 60.
- No objective may receive a score of 0 (Unless an exclusion is claimed).

Meets the Criteria for Promoting Interoperability.

Medicare Promoting Interoperability Program participants are required to report on all the program's objectives and measures or claim an applicable exclusion.

- o "Yes" indicates the facility meets the minimum requirements to be a meaningful E.H.R. user.

- o "No" indicates the facility did not participate or did not meet all program requirements.

A "yes" showcases that a hospital:

- Uses an electronic health information exchange to securely share and receive patient health information with other hospitals and clinicians for referrals and record-keeping.
- Submits or is working to securely submit immunization data to a public health agency and securely gets immunization histories from the public health immunization registry.
- Conducts or reviews a security risk analysis of certified electronic health record technology to address encryption/security of data, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
- Conducts a self-assessment to optimize the safety and safe use of EHRs.
- Submits or is working to securely submit information about cases of infectious diseases to a public health agency.
- Checks prescription drug history using an opioid monitoring program before electronically prescribing an opioid.
- Provides patients electronic access to their health information.

Measure Data Tab

The **Measure Data** tab will display accordions and measures based on the HQR access of the user. If the user has access to inpatient and outpatient data, then the measures for both programs will display for review. Providers who are not participating in either the inpatient or outpatient programs will see the following accordions.

Measure Data	Star Rating	Promoting Interoperability Program

Export Data

Search	Release	Level	Performance	
	October 2024	Select	Select	Clear Filters

+ **Timely and Effective Care**

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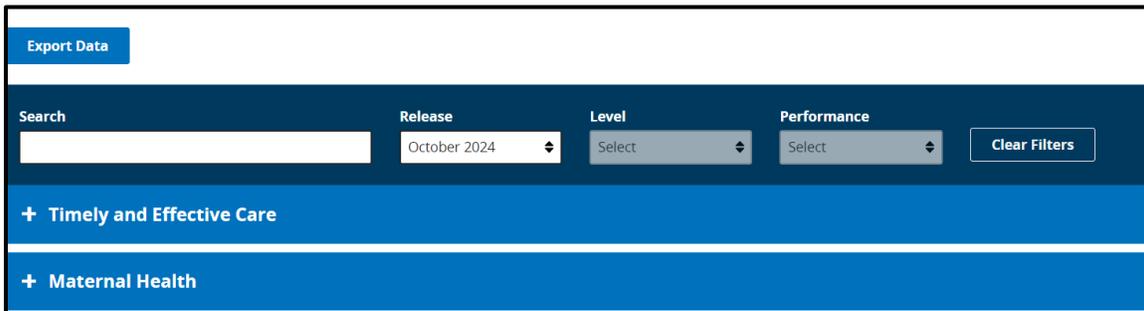
The accordions are labeled similarly to the sections on Care Compare on Medicare.gov and can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

— **Timely and Effective Care**

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ⓘ ED-2-Strata-1	N/A*	N/A*	118 minutes	114 minutes	15 minutes
ⓘ ED-2-Strata-2	N/A*	N/A*	153 minutes	108 minutes	19 minutes

Opioid Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ⓘ Safe Use of Opioids	9%	76	13%	15%	8%

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 can 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.

Accordions

+Timely and Effective Care
Emergency Department Care (ED-2-Strata-1, ED-2-Strata-2)
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)

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 a CEHRT 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.

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 Care Compare 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 Care Compare 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
- 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.

+Maternal Health
Perinatal Care (ePC-02, PC-05, ePC-07a, ePC-07b)

Perinatal Care Measures include:

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

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: 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.

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.

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)

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) 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)
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 Hospitalization for Mental Illness (FUH-7, FUH-30) Medication Continuation Following Inpatient Psychiatric Discharge (MedCont)
Substance Use Treatment	Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (TOB-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 Care Compare 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 Care Compare 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 Care Compare 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.

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

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.