



System Requirements Specification

Hospital Downloadable Database

Data Dictionary

Centers for Medicare & Medicaid Services

<https://www.medicare.gov/care-compare/>

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Introduction

Hospital Care Compare is a consumer-oriented website that provides information on the quality of care hospitals are providing to their patients. This information can help consumers make informed decisions about health care. Hospital Care Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, emergency department care, preventive care, and other conditions. The Centers for Medicare & Medicaid Services (CMS) created the Hospital Care Compare website to better inform health care consumers about a hospital's quality of care. Hospital Care Compare provides data on over 4,000 Medicare-certified hospitals, including acute care hospitals, critical access hospitals (CAHs), children's hospitals, Veterans Health Administration (VHA) Medical Centers, Department of Defence (DoD) and hospital outpatient departments. Hospital Care Compare is part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization, and costs for effective, informed decision-making. More information about Hospital Care Compare can be found by visiting the [CMS.gov](https://www.cms.gov) website and performing a search for Hospital Compare. To access the Hospital Care Compare website, please visit <https://www.medicare.gov/care-compare/>.

Hospital Care Compare is typically updated, or refreshed, each quarter in January, April, July, and October, however, the refresh schedule is subject to change and not all measures will update during each quarterly release.

See the [Measure Descriptions and Reporting Cycles](#) section of this Data Dictionary for additional information. Hospital data are reported in median time only; however, the median time is often referred to as the "average time" to allow for ease of understanding across a wider audience.

Links to download the data from the individual datasets in comma-separated value (CSV) flat file format can be found on the [Provider Data Catalog](#) site with each dataset. To view the Announcements, About the data information, and a link to the data archives, go to the [Topics](#) page.

All Hospital Care Compare websites are publically accessible. As works of the U.S. government, Hospital Care Compare data are in the public domain and permission is not required to reuse them. An attribution to the agency as the source is appreciated. Your materials, however, should not give the false impression of government endorsement of your commercial products or services.

Document Purpose

The purpose of this document is to provide a directory of material for use in the navigation of information contained within the Provider Data Catalog (PDC) downloadable databases. The [Appendix A – Hospital Care Compare Measures](#) section in this data dictionary provides a full list of measures contained in the downloadable databases. The [Measure Dates](#) section of this data dictionary provides additional information about measure dates and quarters.

The following **Specification Manuals** are available on [Qualitynet.cms.gov](https://qualitynet.cms.gov):

- [Specifications Manual for Hospital Inpatient Quality \(IQR\) Measures](#)
- [Hospital Outpatient Quality Reporting \(OQR\) Specifications Manual](#)
- [Ambulatory Surgical Center Quality Reporting Specifications Manual](#)
- [Specification Resources for IPFQR Program Measures](#)
- [PCHQR Program Manual](#)

Acronym Index

The following acronyms are used within this data dictionary and in the corresponding downloadable databases (CSV flat files – Revised):

| Acronym | Meaning |
|-----------|---|
| ASC | Ambulatory Surgical Center |
| ASCQR | Ambulatory Surgical Center Quality Reporting |
| AMI | Acute Myocardial Infarction |
| AVG | Average |
| CABG | Coronary Artery Bypass Graft |
| CAUTI | Catheter-associated urinary tract infections |
| CDI | <i>Clostridium difficile</i> Infection |
| CEBP | Clinical Episode Based Purchasing |
| CJR | Comprehensive Care Joint Replacement |
| CLABSI | Central line-associated bloodstream infections |
| COMP | Complications |
| COPD | Chronic Obstructive Pulmonary Disease |
| DoD | Department of Defense |
| DOPC | Days or Procedure Count |
| ED | Emergency Department |
| EDAC | Excess days in acute care |
| FTNT | Footnote |
| HACRP | Hospital-Acquired Conditions Reduction Program |
| HAI | Healthcare-Associated Infections |
| HBIPS | Hospital-Based Inpatient Psychiatric Services |
| HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems |
| HF | Heart Failure |
| HIP-KNEE | Total Hip/Knee Arthroplasty |
| HIT | Health Information Technology |
| HRRP | Hospital Readmissions Reduction Program |
| HVBP | Hospital Value-Based Purchasing |
| IMG | Imaging |
| IMM | Immunization |
| IPFQR | Inpatient Psychiatric Facility Quality Reporting |
| IQR | Inpatient Quality Reporting |
| MORT | Mortality |
| MRSA | Methicillin-Resistant <i>Staphylococcus aureus</i> |
| MSPB | Medicare Spending per Beneficiary (also referred to as SPP for Spending Per Patient) |
| MSA | Metropolitan Statistical Area |
| MSR | Measure |
| MPV | Medicare Payment and Volume |
| NQF | National Quality Forum |
| OAS CAHPS | Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems |
| OCM | Oncology Care Measures |
| OIE | Outpatient Imaging Efficiency |
| OP | Outpatient |
| OQR | Outpatient Quality Reporting |
| PCHQR | PPS-Exempt Cancer Hospital Quality Reporting |
| PDC | Provider Data Catalog |
| PN | Pneumonia |
| PRO | Patient reported outcomes |
| PSI | Patient Safety Indicators |
| READM | Readmissions |

| | |
|-------|---|
| SEP | Sepsis |
| SM | Structural Measures |
| SMD | Screening for Metabolic Disorder |
| SPP | Spending per Patient (also referred to as MSPB for Medicare Spending per Beneficiary) |
| STK | Stroke |
| THA | Total Hip Arthroplasty |
| TKA | Total Knee Arthroplasty |
| TR | Transition Record |
| TPS | Total Performance Score |
| TRISS | TRICARE Inpatient Satisfaction Surveys |
| VA | Veterans Administration |
| VHA | Veterans Health Administration |
| VOC | Value of care |
| VTE | Venous Thromboembolism |

Measure Descriptions and Reporting Cycles

Data for each measure set are collected in differing time frames from various quality measurement contractors. Additional information about the measure update frequency/refresh schedule and data collection periods can be found in the [Measures and Current Data Collection Periods](#) section of the Care Compare website. Below is a brief description of the collection processes and reporting cycles for each measure set included on Care Compare:

| Name | General Information: Overall Rating |
|----------------------------|--|
| Description/ Background | <p>The Overall Star Ratings are designed to assist patients, consumers, and others in comparing hospitals side-by-side. The Overall Star Ratings show the quality of care a hospital may provide compared to other hospitals based on the quality measures reported on Care Compare. The Overall Star Rating summarizes as many as 50 measures publicly reported on Care Compare into a single rating. The measures come from the IQR, OQR, and other programs and encompass measures in five measure groups: mortality, safety of care, readmission, patient experience, timely & effective care. The hospitals can receive between one and five stars, with five stars being the highest rating, and the more stars, the better the hospital performs on the quality measures. Most hospitals will display a three star rating.</p> <p>For more information, go to the Hospital Care Compare Overall Hospital Quality Star Ratings section.</p> <p>For more information regarding the Overall Hospital Quality Star Ratings methodology, go to the QualityNet.cms.gov Overall Hospital Quality Star Ratings Resources section.</p> |
| Reporting Cycle | Data collection period will vary by measure, and will be updated with each publication. |

| Name | General Information: Health Information Technology (HIT) Measures |
|----------------------------|---|
| Description/ Background | As part of the general information available through CMS, hospitals submit HIT measure data which is part of the Electronic Health Record (EHR) Incentive Program. The data for hospitals who are using certified electronic health record technology to meet the requirements of promoting interoperability is available in the downloadable database files. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually. |

| Name | Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Survey |
|----------------------------|---|
| Description/ Background | The HCAHPS Patient Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. The survey is administered to a random sample of adult inpatients after discharge. The HCAHPS survey contains patient perspectives on care and patient rating items that encompass key topics: communication with hospital staff, responsiveness of hospital staff, communication about medicines, discharge information, cleanliness of hospital environment, quietness of hospital environment, and transition of care. The survey also |

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| | includes screening questions and demographic items, which are used for adjusting the mix of patients across hospitals and for analytic purposes. See Appendix C – HCAHPS Survey Questions Listing section for a full list of current HCAHPS Survey items included in the downloadable databases. More information about the HCAHPS Survey, including a complete list of survey questions, can be found on the official HCAHPS website . |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

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| Name | Timely and Effective Care: Process of Care Measures |
| Description/ Background | The measures of timely and effective care (also known as “process of care” measures) show the percentage of hospital patients who got treatments known to get the best results for certain common, serious medical conditions or surgical procedures; how quickly hospitals treat patients who come to the hospital with certain medical emergencies; and how well hospitals provide preventive services. These measures only apply to patients for whom the recommended treatment would be appropriate. The measures of timely and effective care apply to adults and children treated at hospitals paid under the Inpatient Prospective Payment System (IPPS) or the Outpatient Prospective Payment System (OPPS), as well as those that voluntarily report data on measures for whom the recommended treatments would be appropriate including: Medicare patients, Medicare managed care patients, and non-Medicare patients. Timely and effective care measures include severe sepsis and septic shock, cataract care follow-up, colonoscopy follow-up, heart attack care, preventive care, cancer care, and pregnancy and delivery care measures. |
| Reporting Cycle | Collection period: Approximately 12 months. Refreshed quarterly, except EDV-1, OP-22, OP-29, OP-31,, IMM-3 which are refreshed annually. |

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| Name | Complications: Surgical Complications – Hip/Knee Measure |
| Description/ Background | The Centers for Medicare & Medicaid Services’ (CMS’s) publicly reported risk-standardized complication measure for elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) assesses a broad set of healthcare activities that affect patients' well-being. The hip/knee complication rate is an estimate of complications within an applicable time period, for patients electively admitted for primary total hip and/or knee replacement. CMS measures the likelihood that at least 1 of 8 complications occurs within a specified time period: heart attack, (acute myocardial infarction [AMI]), pneumonia, or sepsis/septicemia/shock during the index admission or within 7 days of admission, surgical site bleeding, pulmonary embolism, or death during the index admission or within 30 days of admission, or mechanical complications or periprosthetic joint infection/wound infection during the index admission or within 90 days of admission. Hospitals’ rates of hip/knee complications are compared to the national rate to determine if hospitals’ performance on this measure is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher). Rates are provided in the downloadable databases as decimals and typically indicate information that is presented on the Hospital Care Compare website as percentages. Lower rates for surgical complications are better. CMS chose to measure these complications within the specified times because complications over a longer period may be impacted by factors outside the hospitals’ control like other complicating illnesses, patients’ own behavior, or care provided to patients after discharge. This measure is separate from the serious complications measure (also reported on Hospital Care Compare). The THA/TKA Methodology for this dataset is available on QualityNet.cms.gov |
| Reporting Cycle | Collection period: 36 months. Refreshed annually. |

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|----------------------------|---|
| Name | Complications: Surgical Complications – CMS Patient Safety Indicators (PSIs) |
| Description/ Background | Measures of serious complications are drawn from the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) . The overall score for serious complications is based on how often adult patients had certain serious, but potentially preventable, complications related to medical or surgical inpatient hospital care. The CMS PSIs reflect quality of care for hospitalized adults and focus on potentially avoidable complications and iatrogenic events. CMS PSIs only apply to Medicare beneficiaries who were discharged from a hospital paid through the IPPS. These indicators are risk adjusted to account for differences in hospital patients’ characteristics. CMS calculates rates for CMS PSIs using Medicare claims data and a statistical model that determines the interval estimates for the PSIs. CMS publicly reports data on two PSIs—PSI-4 (death rate among surgical patients with serious treatable complications) and the composite measure PSI-90. |

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| | <p>PSI-90 is composed of 11 NQF-endorsed measures, including PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax rate), PSI-8 (postoperative hip fracture rate), PSI-9 (postoperative hemorrhage or hematoma rate), PSI-10 (postoperative physiologic and metabolic derangement rate), PSI-11 (postoperative respiratory failure rate), PSI-12 (postoperative pulmonary embolism or deep vein thrombosis rate), PSI-13 (postoperative sepsis rate), PSI-14 (postoperative wound dehiscence rate), and PSI-15 (accidental puncture or laceration rate). PSI-90's composite rate is the weighted average of its component indicators. Hospitals' PSI rates are compared to the national rate to determine if hospitals' performance on PSIs is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher).</p> <p>Please note that the Patient Safety Indicator (PSI)-90 data were not refreshed in July 2017. The data were updated as part of the October 2017 release. Diagnosis coding switched from ICD-9 to ICD-10 in 2015. Data for the FY 2018 recalibrated PSI measures only represent the 15-month performance period of ICD-9 claims (7/1/14 to 9/30/15).</p> |
| Reporting Cycle | Collection period: 24 months. Refreshed annually. |

| Name | Complications: Healthcare-Associated Infections (HAI) Measures |
|----------------------------|---|
| Description/ Background | <p>To receive payment from CMS, hospitals are required to report data about some infections to the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN). The HAI measures show how often patients in a particular hospital contract certain infections during the course of their medical treatment, when compared to like hospitals. HAI measures provide information on infections that occur while the patient is in the hospital and include: central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infection (SSI) from colon surgery or abdominal hysterectomy, methicillin-resistant <i>Staphylococcus Aureus</i> (MRSA) blood laboratory-identified events (bloodstream infections), and <i>Clostridium difficile</i> (<i>C.diff.</i>) laboratory-identified events (intestinal infections). The HAI measures show how often patients in a particular hospital contract certain infections during the course of their medical treatment, when compared to like hospitals. The CDC calculates a Standardized Infection Ratio (SIR) which may take into account the type of patient care location, number of patients with an existing infection, laboratory methods, hospital affiliation with a medical school, bed size of the hospital, patient age, and classification of patient health. SIRs are calculated for the hospital, the state, and the nation. Hospitals' SIRs are compared to the national benchmark to determine if hospitals' performance on these measures is better than the national benchmark (lower), no different than the national benchmark, or worse than the national benchmark (higher). The HAI measures apply to all patients treated in acute care hospitals, including adult, pediatric, neonatal, Medicare, and non-Medicare patients.</p> |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

| Name | Complications: 30-Day Mortality Measures |
|----------------------------|--|
| Description/ Background | <p>The 30-day death measures are estimates of deaths within 30-days of a hospital admission from any cause related to medical conditions, including heart attack (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), and stroke; as well as surgical procedures, including coronary artery bypass graft (CABG). Hospitals' rates are compared to the national rate to determine if hospitals' performance on these measures is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher). For some hospitals, the number of cases is too small to reliably compare their results to the national average rate. CMS chose to measure death within 30 days instead of inpatient deaths to use a more consistent measurement time window because length of hospital stay varies across patients and hospitals. Rates are provided in the downloadable databases as decimals and typically indicate information that is presented on the Hospital Care Compare website as percentages. Lower percentages for readmission and mortality are better.</p> <p>The Mortality Measure Methodology Reports are available on QualityNet.cms.gov.</p> |
| Reporting Cycle | Collection period: 36 months for all measures. |

| Name | Unplanned hospital visits: By Condition |
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|----------------------------|--|
| Description/ Background | <p>The 30-day unplanned readmission measures are estimates of unplanned readmission to any acute care hospital within 30 days of discharge from a hospitalization for any cause related to medical conditions, including heart attack (AMI), heart failure (HF), pneumonia (PN), and chronic obstructive pulmonary disease (COPD). Hospitals' rates are compared to the national rate to determine if hospitals' performance on these measures are better than the national rate (lower), no different than the national rate (the same), or worse than the national rate (higher). For some hospitals, the number of cases is too small to reliably compare their results to the national average rate. The hospital return days measures add up the number of days patients spent back in the hospital (in the emergency department, under observation, or in an inpatient unit) within 30 days after they were first treated and released for AMI and HF. The measures compare each hospital's return days to results from an average hospital with similar patients to determine if this hospital has more, similar, or fewer days than average. Rates are provided in the downloadable databases as decimals and typically indicate information that is presented on the Care Compare website as percentages. Lower percentages for readmission and fewer hospital return days are better.</p> <p>The Readmissions Measure Methodology Reports are available on QualityNet.cms.gov</p> <p>The EDAC Measure Methodology Reports are available on QualityNet.cms.gov.</p> |
| Reporting Cycle | Collection period: 36 months for all measures |

| Unplanned hospital visits: By Procedure | |
|---|---|
| Description/ Background | <p>Measures of unplanned hospital visits show how often patients visit the hospital (in the emergency department, under observation, or in an inpatient hospital unit) after a procedure like coronary artery bypass graft (CABG) surgery, hip/knee replacement, colonoscopy, chemotherapy, and surgical procedures. CABG and hip/knee replacement measures are estimates of the rate of unplanned readmission to an acute care hospital in the 30 days after discharge from hospitalization. The outpatient colonoscopy, chemotherapy and surgery measures are the risk-standardized hospital visit rates (ratio for surgery) after outpatient colonoscopy (per 1000 colonoscopies), chemotherapy (per 100 chemotherapy patients), and surgery procedures respectively. Hospitals' rates for the colonoscopy, chemotherapy, CABG, and hip/knee replacement procedures are compared to the national rate to determine if hospitals' performance is better (lower), no different (the same), or worse (higher) than the national rate. Performance on the surgery measure is categorized as better, no different, or worse than expected by comparing against a ratio of one. Results are provided in the downloadable databases as decimals and typically indicate information that is presented on the Care Compare website. Lower percentages or ratios are better.</p> <p>The Readmissions Measure Methodology Reports are available on QualityNet.cms.gov</p> <p>The Colonoscopy, Chemotherapy, and Surgery Measure Methodology Reports are available on QualityNet.cms.gov</p> |
| Reporting Cycle | Collection period: 36 months for colonoscopy, CABG, and hip/knee replacement measures; 12 months for chemotherapy and surgery measures. |

| Unplanned hospital visits: Overall | |
|------------------------------------|---|
| Description/ Background | <p>The 30-day unplanned hospital-wide readmission measure focuses on whether patients who were discharged from a hospitalization were hospitalized again within 30 days. The hospital-wide readmission measure includes all medical, surgical and gynecological, neurological, cardiovascular, and cardiorespiratory patients. Hospitals' rates are compared to the national rate to determine if hospitals' performance on these measures are better than the national rate (lower), no different than the national rate (the same), or worse than the national rate (higher). For some hospitals, the number of cases is too small to reliably compare their results to the national average rate. Rates are provided in the downloadable databases as decimals and typically indicate information that is presented on the Care Compare website as percentages. Lower percentages are better.</p> <p>The Hospital-Wide Readmission Measure Methodology Report is available on QualityNet.cms.gov</p> |
| Reporting Cycle | Collection period: 12 months |

| Name | Use of Medical Imaging: Outpatient Imaging Efficiency (OIE) |
|----------------------------|---|
| Description/ Background | CMS has adopted three measures which capture the quality of outpatient care in the area of imaging. CMS notes that the purpose of these measures is to promote high-quality efficient care. Each of the measures currently utilize both the Hospital OPPS claims and Physician Part B claims in the calculations. These calculations are based on the administrative claims of the Medicare fee-for-service population. Hospitals do not submit additional data for these measures. The measures on the use of medical imaging show how often a hospital provides specific imaging tests for Medicare beneficiaries under circumstances where they may not be medically appropriate. Lower percentages suggest more efficient use of medical imaging. The purpose of reporting these measures is to reduce unnecessary exposure to contrast materials and/or radiation, to ensure adherence to evidence-based medicine and practice guidelines, and to prevent wasteful use of Medicare resources. The measures only apply to Medicare patients treated in hospital outpatient departments. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually. |

| Name | Payment and Value of Care Measures |
|----------------------------|---|
| Description/ Background | <p>The Medicare Spending Per Beneficiary (MSPB-1) Measure assesses Medicare Part A and Part B payments for services provided to a Medicare beneficiary during a spending-per-beneficiary 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.</p> <p>The payment measures for heart attack, heart failure, pneumonia, and hip/knee replacement include the payments made for Medicare beneficiaries who are 65 years and older. The measures add up payments made for care and supplies starting the day the patient enters the hospital and for the next 30 days or 90 days for hip/knee replacement. The measures are meant to reflect differences in the services and supplies provided to patients.</p> <p>Hospital results are provided in the downloadable databases for the heart attack, heart failure, pneumonia, and hip/knee replacement payment measures. You can see whether the payments made for patients treated at a particular hospital is less than, no different than, or greater than the national average payment. For some hospitals, the number of cases is too small to reliably compare their results to the national average payment.</p> <p>The Payment Measure Methodology Reports and MSBP Measure Methodology Reports are available on QualityNet.cms.gov.</p> |
| Reporting Cycle | Collection Period: 12 months for MSPB-1 and CEBP measures, and 36 months for the payment for heart attack (PAYM-30-AMI), heart failure (PAYM-30-HF), pneumonia (PAYM-30-PN) measures, and hip/knee replacement (PAY-90-HIP-KNEE). All measures are refreshed annually. |

| Name | Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program |
|----------------------------|--|
| Description/ Background | The IPFQR Program is a pay-for-reporting program intended to provide consumers with quality of care information to make more informed decisions about health care options. To meet the IPFQR Program requirements, Inpatient Psychiatric Facilities (IPFs) are required to submit all quality measures to CMS. The IPFQR Program measures allow consumers to find and compare the quality of care given at psychiatric facilities where patients are admitted as inpatients. Inpatient psychiatric facilities are required to report data on these measures. Facilities that are eligible for this program may have their Medicare payments reduced if they do not report. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually. |

| Name | Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program |
|----------------------------|---|
| Description/ Background | The PPS-Exempt Cancer Hospital Quality Reporting Program measures allow consumers to find and compare the quality of care provided at the eleven PPS-exempt cancer hospitals participating in the program. Under the PCHQR Program, cancer hospitals submit data to CMS for Cancer-specific Treatment Measures: PPS-Exempt Cancer Hospitals also submit the following HCAHPS measures: Composite 1 (Q1 to Q3), Composite 2 (Q5 to Q7), Composite 3 (Q4 & Q11), Composite 5 (Q16 & Q17), Composite 6 (Q19 & Q20), Composite 7 (Q23 to Q25), Q21, Q 22, the star ratings and linear score PPS-Exempt Cancer Hospitals submit Oncology Care Measures (PCH -14 through PCH -18). PPS-Exempt Cancer Hospitals additionally submit a Clinical Effectiveness Measure (PCH -25). PPS-Exempt surgical site infection (SSI) from colon surgery or abdominal |

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| | hysterectomy (PCH-07), methicillin-resistant <i>Staphylococcus Aureus</i> (MRSA) (PCH-27), and <i>Clostridium difficile</i> (<i>C.diff.</i>) laboratory-identified events (intestinal infections) PCH-26). PPS-Exempt Cancer Hospitals also report Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (PCH-28). PPS-Exempt Cancer Hospitals submit Emergency Department measures PCH-30 and PCH-31. |
| Reporting Cycle | Collection period: 12 months for the PCH and Composite HCAHPS measures. PCH measures are refreshed annually. Composite HCAHPS measures are refreshed quarterly. The PCH HAI measures are refreshed quarterly. |

| | |
|----------------------------|---|
| Name | Ambulatory Surgical Center Quality Reporting (ASCQR) Program |
| Description/ Background | The Ambulatory Surgical Center Quality Reporting (ASCQR) Program is a quality measure data reporting program implemented by the Centers for Medicare & Medicaid Services (CMS) for care provided in the ambulatory surgical center (ASC) setting. ASCs are health care facilities that perform surgeries and procedures outside the hospital setting. The ASCQR Program exists to promote higher quality, more efficient health care for Medicare beneficiaries through data reporting, quality improvement, and measure alignment with other clinical care settings. To participate in the program, an ASC must submit quality measure data. Once an ASC submits quality measure data under the ASCQR Program for any of the ASCQR measures, the ASC is considered to be participating in the program. ASCs that participate in the program and meet program requirements are rewarded based on the quality of care that they provide to patients. The program operates by (1) awarding ASCs that meet program requirements with an annual payment, and (2) reducing the annual payment by two percent for ASCs that do not participate in the program, or fail to meet program requirements for the ten ASC measures. |
| Reporting Cycle | Collection period: 12 months (ASC -9, -11, -12, -13, -14, -17, -18). Refreshed annually. |

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|----------------------------|--|
| Name | Hospital-Acquired Conditions Reduction Program (HACRP) |
| Description/ Background | Hospital-Acquired Condition (HAC) Reduction Program - In October 2014, CMS began reducing Medicare payments for subsection (d) hospitals that rank in the worst-performing quartile with respect to HAC quality measures. Hospitals with a Total HAC Score above the 75th percentile of the Total HAC Score distribution will be subject to a 1-percent payment reduction. This table contains hospitals' measure and Total HAC scores. The Total HAC Score is the equally weighted average of individual measure scores. Details regarding the HACRP Overview and Scoring Methodology are available on QualityNet.cms.gov. |
| Reporting Cycle | Collection Period: 15 months (HACRP Domain 1 Score, and PSI-90); 24 months (HACRP Domain 2 Score, CAUTI, CDI, CLABSI, MRSA and SSI); 30 months (Total HAC Score). Refreshed Annually. |

| | |
|----------------------------|---|
| Name | Hospital Readmissions Reduction Program (HRRP) |
| Description/ Background | In October 2012, CMS began reducing Medicare payments for subsection(d) hospitals with excess readmissions. Excess readmissions are measured by a ratio, calculated by dividing a hospital's predicted rate of readmission for heart attack (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), hip/knee replacement (THA/TKA), and coronary artery bypass graft surgery (CABG) by the expected rate of readmission, based on an average hospital with similar patients. The HRRP Overview is available on QualityNet.cms.gov. |
| Reporting Cycle | Collection period: 36 months. Refreshed annually. |

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| Name | Linking Quality to Payment: Hospital Value-Based Purchasing (HVBP) Program |
| Description/ Background | The HVBP program is part of CMS' long-standing effort to link Medicare's payment system to quality. The program implements value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,000 hospitals across the country. Hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. The Fiscal Year 2018 HVBP program adjusts hospitals' payments based on their performance on four domains that reflect hospital quality: (1) Clinical Care, (2) Patient- and Caregiver- Centered Experience of Care/Care Coordination, (3) Safety, and (4) Efficiency and Cost Reduction. The domains consist of measures for Safety, Patient Experience of Care, Clinical Care Outcomes, Perinatal Outcomes, and Efficiency. The Total Performance Score (TPS) is comprised of the scores from the following domains: Clinical Care domain score (weighted as 25 percent of the TPS), the Patient- and Caregiver-Centered Experience of Care/Care |

| | |
|-----------------|---|
| | <p>Coordination domain score (weighted as 25 percent of the TPS), the Safety domain score (weighted as 25 percent of the TPS), and the Efficiency and Cost Reduction domain score (weighted as 25 percent of the TPS).</p> <p>The HVBP measure dates are available the HVBP Overview page on QualityNet.cms.gov and Measures are available on QualityNet.cms.gov.</p> |
| Reporting Cycle | Collection period: 12 months for Patient- and Caregiver- Centered Experience of Care/Care Coordination domain, and for Efficiency and Cost Reduction domain, 12 months and 15 months for Safety domain measures (CMS, HAI), and 33 months for Clinical Care domain. Refreshed annually. |

| | |
|----------------------------|--|
| Name | Linking Quality to Payment: HVBP Payment Adjustments |
| Description/ Background | The Inpatient HVBP Program adjusts Medicare's payments to reward hospitals based on the quality of care that they provide to patients. The program operates by first reducing participating hospitals' Medicare payments by a specified percentage, then by using the estimated total amount of those payment reductions to fund value-based incentive payments to hospitals based on their performance under the program. |
| Reporting Cycle | Collection period: Approximately 12 months. Refreshed annually. |

| | |
|----------------------------|---|
| Name | Comprehensive Care for Joint Replacement Model |
| Description/ Background | <p>The Comprehensive Care for Joint Replacement (CJR) model encourages physicians, hospitals, and post-acute care providers to work together to improve quality of care for patients undergoing hip and knee replacement inpatient surgeries. This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. The CJR model tracks two quality measures during an episode of care:</p> <ul style="list-style-type: none"> • Complication rate for hip/knee replacement patients (Hospital-level risk-standardized complication rate [RSCR] following Total Hip Arthroplasty [THA] and/or Total Knee Arthroplasty [TKA])) (NQF #1550) • Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166), calculated as an HCAHPS Linear Mean Roll-Up Score <p>The CJR model also encourages hospitals to voluntarily submit data on patient-reported outcomes (PROs) for patients undergoing hip/knee replacements (THA/TKA PROs) and limited data on risk variables (race and ethnicity, body mass index [BMI] or weight and height, and patient health literacy).</p> |
| Reporting Cycle | Collection period: CJR HCAHPS – 12 months, refreshed annually, CJR Hip/Knee Complications – 36 months. Refreshed annually. PRO data is refreshed annually. |

| | |
|----------------------------|---|
| Name | Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey |
| Description/ Background | <p>The OAS CAHPS® Patient Survey is a survey instrument and data collection methodology for measuring patients' perceptions of their outpatient and ambulatory surgical center experience. The survey is administered to a random sample of adult outpatient patients after discharge. The OAS CAHPS survey contains patient perspectives on care and patient rating items that encompass key topics: communication with facility staff, responsiveness of facility staff, pain management, communication about medicines, discharge information, cleanliness of facility environment, quietness of facility environment, and transition of care. The survey also includes screening questions and demographic items, which are used for adjusting the mix of patients across facilities and for analytic purposes. See the Appendix D – OAS CAHPS Survey Questions Listing section for a full list of current OAS CAHPS Survey items included in the downloadable databases. More information about the OAS CAHPS Survey, including a complete list of survey questions, can be found on the official OAS CAHPS website.</p> <p>This file contains the footnotes used in the Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS) survey data. The OAS CAHPS survey collects information about patients' experiences of care in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs).</p> |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

Measure Dates

The downloadable databases are refreshed within 24 hours of the Hospital Care Compare data update. The Measure Dates file located within the downloadable databases contains a comprehensive listing of all measures displayed on Hospital Care Compare, their start quarters and dates, and their end quarters and dates. A sample of the collection periods from the January 2022 Measure Dates file is shown below:

| Measure ID | Measure Start Quarter | Start Date | Measure End Quarter | End Date |
|--------------------------------|-----------------------|------------|---------------------|------------|
| COMP_HIP_KNEE | 2Q2017 | 4/1/2017 | 4Q2019 | 10/2/2019 |
| COMP_HIP_KNEE_HVBP_Baseline | 2Q2011 | 4/1/2011 | 1Q2014 | 3/31/2014 |
| COMP_HIP_KNEE_HVBP_Performance | 2Q2016 | 4/1/2016 | 1Q2019 | 3/31/2019 |
| EDAC_30_AMI | 3Q2017 | 7/1/2017 | 4Q2019 | 12/1/2019 |
| EDAC_30_HF | 3Q2017 | 7/1/2017 | 4Q2019 | 12/1/2019 |
| EDAC_30_PN | 3Q2017 | 7/1/2017 | 4Q2019 | 12/1/2019 |
| EDV | 3Q2020 | 7/1/2020 | 4Q2020 | 12/31/2020 |
| FUH_30 | 3Q2019 | 7/1/2019 | 4Q2019 | 12/31/2019 |
| FUH_7 | 3Q2019 | 7/1/2019 | 4Q2019 | 12/31/2019 |
| HACRP_CAUTI | 1Q2018 | 1/1/2018 | 4Q2019 | 12/31/2019 |
| HACRP_CDI | 1Q2018 | 1/1/2018 | 4Q2019 | 12/31/2019 |
| HACRP_CLABSI | 1Q2018 | 1/1/2018 | 4Q2019 | 12/31/2019 |
| HACRP_MRSA | 1Q2018 | 1/1/2018 | 4Q2019 | 12/31/2019 |
| HACRP_PSI90 | 3Q2017 | 7/1/2017 | 2Q2019 | 6/30/2019 |
| HACRP_SSI | 1Q2018 | 1/1/2018 | 4Q2019 | 12/31/2019 |
| HACRP_Total | 3Q2017 | 7/1/2017 | 4Q2019 | 12/31/2019 |
| HAI_1 | 4Q2019 | ##### | 1Q2021 | 3/31/2021 |
| HAI_1_HVBP_Baseline | 1Q2017 | 1/1/2017 | 4Q2017 | 12/31/2017 |
| HAI_1_HVBP_Performance | 1Q2019 | 1/1/2019 | 4Q2019 | 12/31/2019 |
| HAI_2 | 4Q2019 | ##### | 1Q2021 | 3/31/2021 |
| HAI_2_HVBP_Baseline | 1Q2017 | 1/1/2017 | 4Q2017 | 12/31/2017 |
| HAI_2_HVBP_Performance | 1Q2019 | 1/1/2019 | 4Q2019 | 12/31/2019 |
| COMP_HIP_KNEE | 2Q2017 | 4/1/2017 | 4Q2019 | 10/2/2019 |
| COMP_HIP_KNEE_HVBP_Baseline | 2Q2011 | 4/1/2011 | 1Q2014 | 3/31/2014 |
| COMP_HIP_KNEE_HVBP_Performance | 2Q2016 | 4/1/2016 | 1Q2019 | 3/31/2019 |

File Summary

The table below shows the titles of all .CSV Revised file names included in the downloadable database. A “HospitalCompare-DataDictionary.pdf” (Data Dictionary) file is included with the downloadable databases format. Archived datasets are available for releases May 2005 – October 2021.

| File Name on https://data.cms.gov/provider-data/ |
|--|
| ASC_Facility.csv |
| ASC_National.csv |
| ASC_State.csv |
| ASCQR_OAS_CAHPS_BY_ASC.csv |
| ASCQR_OAS_CAHPS_NATIONAL.csv |
| ASCQR_OAS_CAHPS_STATE.csv |
| CJR_PY5_Quality_Reporting_July_2021_Production_File.csv |
| CMS_PSI_6_decimal_file.csv |
| Complications_and_Deaths-Hospital.csv |
| Complications_and_Deaths-National.csv |
| Complications_and_Deaths-State.csv |
| Data_Updates_January_2022.csv |
| Footnote_Crosswalk.csv |
| OAS_CAHPS_Footnotes.csv |
| FY2019_Distribution_of_Net_Change_in_Base_Op_DRG_Payment_Amt.csv |
| FY2019_Net_Change_in_Base_Op_DRG_Payment_Amt.csv |
| FY2019_Percent_Change_in_Medicare_Payments.csv |
| FY2019_Value_Based_Incentive_Payment_Amount.csv |
| HCAHPS-Hospital.csv |
| HCAHPS-National.csv |
| HCAHPS-State.csv |
| Healthcare_Associated_Infections-Hospital.csv |
| Healthcare_Associated_Infections-National.csv |
| Healthcare_Associated_Infections-State.csv |
| OQR_OAS_CAHPS_BY_HOSPITAL.csv |

| |
|--|
| OQR_OAS_CAHPS_NATIONAL.csv |
| OQR_OAS_CAHPS_STATE.csv |
| Hospital_General_Information.csv |
| PCH_ONCOLOGY_CARE_MEASURES_HOSPITAL.csv |
| PCH_OUTCOMES_HOSPITAL.csv |
| PCH_OUTCOMES_NATIONAL.csv |
| FY_2022_HAC_Reduction_Program_Hospital.csv |
| HOSPITAL_QUARTERLY_MSPB_6_DECIMALS.csv |
| PCH_HEALTHCARE_ASSOCIATED_INFECTIONS_HOSPITAL.csv |
| PCH_HCAHPS_HOSPITAL.csv |
| PCH_HCAHPS_NATIONAL.csv |
| PCH_HCAHPS_STATE.csv |
| FY_2022_Hospital_Readmissions_Reduction_Program_Hospital.csv |
| hvpb_clinical_outcomes.csv |
| hvpb_efficiency_and_cost_reduction.csv |
| hvpb_person_and_community_engagement.csv |
| hvpb_safety.csv |
| hvpb_tps.csv |
| IPFQR_QualityMeasures_Facility.csv |
| IPFQR_QualityMeasures_National.csv |
| IPFQR_QualityMeasures_State.csv |
| Measure_Dates.csv |
| Medicare_Hospital_Spending_by_Claim.csv |
| Medicare_Hospital_Spending_Per_Patient-Hospital.csv |
| Medicare_Hospital_Spending_Per_Patient-National.csv |
| Medicare_Hospital_Spending_Per_Patient-State.csv |
| Outpatient_Imaging_Efficiency-Hospital.csv |
| Outpatient_Imaging_Efficiency-National.csv |
| Outpatient_Imaging_Efficiency-State.csv |

| |
|--|
| Payment-National.csv |
| Payment-State.csv |
| Payment_and_Value_of_Care-Hospital.csv |
| Timely_and_Effective_Care-Hospital.csv |
| Timely_and_Effective_Care-National.csv |
| Timely_and_Effective_Care-State.csv |
| Unplanned_Hospital_Visits-Hospital.csv |
| Unplanned_Hospital_Visits-National.csv |
| Unplanned_Hospital_Visits-State.csv |
| VA_IPF.csv |
| VA_TE.csv |
| Value_of_Care-National.csv |
| Veterans_Health_Administration_Provider_Level_Data.csv |

Downloadable Database Content Summary

CSV Flat Files Note: Opening CSV files in Excel will remove leading zeroes from data fields. Since some data, such as provider numbers, contain leading zeroes, it is recommended that you open CSV files using text editor programs such as Notepad to copy or view CSV file content. Fields having the data type of “Memo” do not require a length. They allow the user to input large amounts of text without limit. Fields having the data type of “Char” require the corresponding length provided. The CSV column names, and file names should mirror the datasets found on Data.Medicare.gov. Archived data in Microsoft Access and zipped comma-separated value (CSV) flat file formats from 2005 - 2021 are available in the Data Archive [page](#) found in the Hospital [Topics](#) section of the Provider Data Catalog site.

General Information

| | |
|---|---|
| Table (Back to File Summary) | Hospital General Information |
| Description | General information on hospitals within the dataset |
| File Name | HOSPITAL_GENERAL_INFORMATION.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |
| Char(51) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(34) | Hospital Type |
| Char(43) | Hospital Ownership |
| Char(3) | Emergency Services |
| Char(1) | Meets criteria for promoting interoperability of EHRs |
| Char(13) | Hospital overall rating |
| Num(8) | Hospital overall rating footnote |
| Char(13) | MORT Group Measure Count |
| Char(13) | Count of Facility MORT Measures |
| Char(13) | Count of MORT Measures Better |
| Char(13) | Count of MORT Measures No Different |
| Char(13) | Count of MORT Measures Worse |

| | |
|---|---|
| Table (Back to File Summary) | Hospital General Information |
| Description | General information on hospitals within the dataset |
| File Name | HOSPITAL_GENERAL_INFORMATION.CSV |
| Data Type | Column Name - CSV |
| Num(8) | MORT Group Footnote |
| Char(13) | Safety Group Measure Count |
| Char(13) | Count of Facility Safety Measures |
| Char(13) | Count of Safety Measures Better |
| Char(13) | Count of Safety Measures No Different |
| Char(13) | Count of Safety Measures Worse |
| Num(8) | Safety Group Footnote |
| Char(13) | READM Group Measure Count |
| Char(13) | Count of Facility READM Measures |
| Char(13) | Count of READM Measures Better |
| Char(13) | Count of READM Measures No Different |
| Char(13) | Count of READM Measures Worse |
| Num(8) | READM Group Footnote |
| Char(13) | Pt Exp Group Measure Count |
| Char(13) | Count of Facility Pt Exp Measures |
| Num(8) | Pt Exp Group Footnote |
| Char(13) | TE Group Measure Count |
| Char(13) | Count of Facility TE Measures |
| Num(8) | TE Group Footnote |

| | |
|---|---|
| Table (Back to File Summary) | Measure Dates |
| Description | Current collection dates for all measures in Hospital Provider Data Catalog and Hospital Care Compare |
| File Name | MEASURE_DATES.CSV |
| Data Type | Column Name - CSV |
| Char(30) | Measure ID |
| Char(110) | Measure Name |

| | |
|---|---|
| Table (Back to File Summary) | Measure Dates |
| Description | Current collection dates for all measures in Hospital Provider Data Catalog and Hospital Care Compare |
| File Name | MEASURE_DATES.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Measure Start Quarter |
| Date | Start Date |
| Char(6) | Measure End Quarter |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Data Updates |
| Description | Lists the data updates for a scheduled quarterly refresh and as well those that are updated in between refreshes. |
| File Name | DATA_UPDATES_JANUARY_2022.CSV |
| Data Type | Column Name - CSV |
| Char(118) | https://data.cms.gov/provider-data/ location affected |
| Char(155) | Downloadable CSV revised file affected |
| Num(8) | Data Last Updated |
| Char(669) | Data Last Updated Details |

| | |
|---|---|
| Table (Back to File Summary) | Footnote Crosswalk |
| Description | Look up table for footnote summary text |
| File Name | FOOTNOTE_CROSSWALK.CSV |
| Data Type | Column Name - CSV |
| Char(3) | Footnote |
| Char(226) | Footnote Text |

Survey of Patients' Experiences

| | |
|---|---|
| Table (Back to File Summary) | HCAHPS (Hospital) |
| Description | Hospital-level results for the Hospital Consumer Assessment of Healthcare Providers and Systems |
| File Name | HCAHPS-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |
| Char(42) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(25) | HCAHPS Measure ID |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Char(14) | Patient Survey Star Rating |
| Char(7) | Patient Survey Star Rating Footnote |
| Char(14) | HCAHPS Answer Percent |
| Char(7) | HCAHPS Answer Percent Footnote |
| Char(14) | HCAHPS Linear Mean Value |
| Char(13) | Number of Completed Surveys |
| Char(7) | Number of Completed Surveys Footnote |
| Char(13) | Survey Response Rate Percent |
| Char(7) | Survey Response Rate Percent Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | HCAHPS (National) |
| Description | National-level results for the Hospital Consumer Assessment of Healthcare Providers and Systems |
| File Name | HCAHPS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(21) | HCAHPS Measure ID |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Num(8) | HCAHPS Answer Percent |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | HCAHPS (State) |
| Description | State-level results for the Hospital Consumer Assessment of Healthcare Providers and Systems |
| File Name | HCAHPS-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(21) | HCAHPS Measure ID |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Char(13) | HCAHPS Answer Percent |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

Timely and Effective Care

| | |
|---|---|
| Table (Back to File Summary) | Timely and Effective Care (Hospital) |
| Description | Hospital-level results for Process of Care measures |
| File Name | TIMELY_AND_EFFECTIVE_CARE-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |

| | |
|---|---|
| Table (Back to File Summary) | Timely and Effective Care (Hospital) |
| Description | Hospital-level results for Process of Care measures |
| File Name | TIMELY_AND_EFFECTIVE_CARE-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(72) | Facility Name |
| Char(51) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(27) | Condition |
| Char(11) | Measure ID |
| Char(168) | Measure Name |
| Char(13) | Score |
| Char(13) | Sample |
| Char(13) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Timely and Effective Care (National) |
| Description | National-level results for Process of Care measures |
| File Name | TIMELY_AND_EFFECTIVE_CARE-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(21) | Measure ID |
| Char(195) | Measure Name |
| Char(27) | Condition |
| Char(132) | Category |
| Num(8) | Score |
| Char(8) | Footnote |

| | |
|---|---|
| Table (Back to File Summary) | Timely and Effective Care (National) |
| Description | National-level results for Process of Care measures |
| File Name | TIMELY_AND_EFFECTIVE_CARE-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | Timely and Effective Care (State) |
| Description | State-level results for Process of Care measures |
| File Name | TIMELY_AND_EFFECTIVE_CARE-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(27) | Condition |
| Char(20) | Measure ID |
| Char(195) | Measure Name |
| Char(13) | Score |
| Char(8) | Footnote |
| Date | Start Date |
| Date | End Date |

Complications and Deaths

| | |
|---|--|
| Table (Back to File Summary) | Complications and Deaths (Hospital) |
| Description | Hospital-level results for surgical complications and mortality measures |
| File Name | COMPLICATIONS_AND_DEATHS-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |

| | |
|---|--|
| Table (Back to File Summary) | Complications and Deaths (Hospital) |
| Description | Hospital-level results for surgical complications and mortality measures |
| File Name | COMPLICATIONS_AND_DEATHS-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(39) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(13) | Measure ID |
| Char(73) | Measure Name |
| Char(36) | Compared to National |
| Char(14) | Denominator |
| Char(13) | Score |
| Char(13) | Lower Estimate |
| Char(13) | Higher Estimate |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | Complications and Deaths (National) |
| Description | National-level results for surgical complications and mortality measures |
| File Name | COMPLICATIONS_AND_DEATHS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(13) | Measure ID |
| Char(73) | Measure Name |
| Num(8) | National Rate |
| Num(8) | Number of Hospitals Worse |

| | |
|---|--|
| Table (Back to File Summary) | Complications and Deaths (National) |
| Description | National-level results for surgical complications and mortality measures |
| File Name | COMPLICATIONS_AND_DEATHS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Number of Hospitals Same |
| Num(8) | Number of Hospitals Better |
| Char(13) | Number of Hospitals Too Few |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Complications and Deaths (State) |
| Description | State-level results for surgical complications and mortality measures |
| File Name | COMPLICATIONS_AND_DEATHS-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(13) | Measure ID |
| Char(73) | Measure Name |
| Char(13) | Number of Hospitals Worse |
| Char(13) | Number of Hospitals Same |
| Char(13) | Number of Hospitals Better |
| Char(13) | Number of Hospitals Too Few |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | PSI 6 Decimals |
| Description | CMS PSI-90 and component measures by facility displayed to 6 decimals |
| File Name | CMS_PSI_6_DECIMAL_FILE.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |
| Char(39) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County |
| Char(6) | Measure ID |
| Char(64) | Measure Name |
| Char(13) | Rate |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

Healthcare-associated Infections (HAI)

| | |
|---|--|
| Table (Back to File Summary) | HAI (Hospital) |
| Description | Hospital-level results for healthcare-associated infections measures |
| File Name | HEALTHCARE_ASSOCIATED_INFECTIONS-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |
| Char(39) | Address |
| Char(17) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(15) | Measure ID |
| Char(98) | Measure Name |
| Char(36) | Compared to National |
| Char(13) | Score |
| Char(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | HAI (National) |
| Description | National-level results for healthcare-associated infections measures |
| File Name | HEALTHCARE_ASSOCIATED_INFECTIONS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(9) | Measure ID |

| | |
|---|--|
| Table (Back to File Summary) | HAI (National) |
| Description | National-level results for healthcare-associated infections measures |
| File Name | HEALTHCARE_ASSOCIATED_INFECTIONS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(66) | Measure Name |
| Num(8) | Score |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | HAI (State) |
| Description | State-level results for healthcare-associated infections measures |
| File Name | HEALTHCARE_ASSOCIATED_INFECTIONS-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(13) | Measure ID |
| Char(90) | Measure Name |
| Char(13) | Score |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

Unplanned Hospital Visits

| | |
|---|--|
| Table (Back to File Summary) | Unplanned Hospital Visits (Hospital) |
| Description | Hospital-level results for 30-day readmissions measures and hospital return days |
| File Name | UNPLANNED_HOSPITAL_VISITS-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(72) | Facility Name |
| Char(39) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(18) | Measure ID |
| Char(87) | Measure Name |
| Char(42) | Compared to National |
| Char(13) | Denominator |
| Char(13) | Score |
| Char(13) | Lower Estimate |
| Char(13) | Higher Estimate |
| Char(14) | Number of Patients |
| Char(14) | Number of Patients Returned |
| Char(7) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | Unplanned Hospital Visits (National) |
| Description | National-level results for 30-day readmissions measures and hospital return days |
| File Name | UNPLANNED_HOSPITAL_VISITS-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(18) | Measure ID |
| Char(87) | Measure Name |
| Char(14) | National Rate |
| Char(14) | Number of Hospitals Worse |
| Char(14) | Number of Hospitals Same |
| Char(14) | Number of Hospitals Better |
| Char(14) | Number of Hospitals Too Few |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |
| Char(14) | Number of Hospitals Fewer |
| Char(14) | Number of Hospitals Average |
| Char(14) | Number of Hospitals More |
| Char(14) | Number of Hospitals Too Small |

| | |
|---|---|
| Table (Back to File Summary) | Unplanned Hospital Visits (State) |
| Description | State-level results for 30-day readmissions measures and hospital return days |
| File Name | UNPLANNED_HOSPITAL_VISITS-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(18) | Measure ID |
| Char(87) | Measure Name |
| Char(14) | Number of Hospitals Worse |
| Char(14) | Number of Hospitals Same |
| Char(14) | Number of Hospitals Better |

| | |
|---|---|
| Table (Back to File Summary) | Unplanned Hospital Visits (State) |
| Description | State-level results for 30-day readmissions measures and hospital return days |
| File Name | UNPLANNED_HOSPITAL_VISITS-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(14) | Number of Hospitals Too Few |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |
| Char(14) | Number of Hospitals Fewer |
| Char(14) | Number of Hospitals Average |
| Char(14) | Number of Hospitals More |
| Char(14) | Number of Hospitals Too Small |

Use of Medical Imaging

| | |
|---|---|
| Table (Back to File Summary) | Outpatient Imaging Efficiency (Hospital) |
| Description | Hospital-level results for measures of the use of medical imaging |
| File Name | OUTPATIENT_IMAGING_EFFICIENCY-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(72) | Facility Name |
| Char(51) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(5) | Measure ID |
| Char(83) | Measure Name |

| | |
|---|---|
| Table (Back to File Summary) | Outpatient Imaging Efficiency (Hospital) |
| Description | Hospital-level results for measures of the use of medical imaging |
| File Name | OUTPATIENT_IMAGING_EFFICIENCY-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(13) | Score |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Outpatient Imaging Efficiency (National) |
| Description | National-level results for measures of the use of medical imaging |
| File Name | OUTPATIENT_IMAGING_EFFICIENCY-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(5) | Measure ID |
| Char(83) | Measure Name |
| Num(8) | Score |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | Outpatient Imaging Efficiency (State) |
| Description | State-level results for measures of the use of medical imaging |
| File Name | OUTPATIENT_IMAGING_EFFICIENCY-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(5) | Measure ID |
| Char(83) | Measure Name |
| Char(13) | Score |

| | |
|---|--|
| Table (Back to File Summary) | Outpatient Imaging Efficiency (State) |
| Description | State-level results for measures of the use of medical imaging |
| File Name | OUTPATIENT_IMAGING_EFFICIENCY-STATE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

Payment and Value of Care

| | |
|---|--|
| Table (Back to File Summary) | Payment and Value of Care (Hospital) |
| Description | Hospital-level results for payment measures and value of care displays associated with 30-day mortality measures |
| File Name | PAYMENT_AND_VALUE_OF_CARE-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(72) | Facility Name |
| Char(51) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(16) | Payment Measure ID |
| Char(41) | Payment Measure Name |
| Char(46) | Payment Category |
| Char(13) | Denominator |
| Char(13) | Payment |
| Char(13) | Lower Estimate |
| Char(13) | Higher Estimate |

| | |
|---|--|
| Table (Back to File Summary) | Payment and Value of Care (Hospital) |
| Description | Hospital-level results for payment measures and value of care displays associated with 30-day mortality measures |
| File Name | PAYMENT_AND_VALUE_OF_CARE-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Payment Footnote |
| Char(21) | Value of Care Display ID |
| Char(34) | Value of Care Display Name |
| Char(41) | Value of Care Category |
| Num(8) | Value of Care Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Payment (National) |
| Description | National-level results for payment measures |
| File Name | PAYMENT-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(16) | Measure ID |
| Char(41) | Measure Name |
| Char(9) | National Payment |
| Num(8) | Number Less Than National Payment |
| Num(8) | Number Same as National Payment |
| Num(8) | Number Greater Than National Payment |
| Num(8) | Number of Hospitals Too Few |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | Payment (State) |
| Description | State-level results for payment measures |
| File Name | PAYMENT-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(16) | Measure ID |
| Char(41) | Measure Name |
| Char(13) | Number Less Than National Payment |
| Char(13) | Number Same as National Payment |
| Char(13) | Number Greater Than National Payment |
| Char(13) | Number of Hospitals Too Few |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | Value of Care (National) |
| Description | National-level results for value of care displays associated with 30-day mortality measures |
| File Name | VALUE_OF_CARE-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(50) | Value of Care Measure ID |
| Char(89) | Value of Care Measure Name |
| Num(8) | Number of Hospitals |
| Date | Start Date |
| Date | End Date |

Medicare Spending per Beneficiary (MSPB)

| | |
|---|---|
| Table (Back to File Summary) | MSPB 6 Decimals |
| Description | Medicare Spending per Beneficiary by facility displayed to 6 decimals |
| File Name | HOSPITAL_QUARTERLY_MSPB_6_DECIMALS.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(6) | Measure ID |
| Char(8) | Value |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | MSPB (Hospital) |
| Description | Hospital-level Medicare Spending per Beneficiary |
| File Name | MEDICARE_HOSPITAL_SPENDING_PER_PATIENT-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(72) | Facility Name |
| Char(51) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(25) | County Name |
| Char(14) | Phone Number |
| Char(6) | Measure ID |
| Char(74) | Measure Name |
| Char(13) | Score |
| Char(7) | Footnote |

| | |
|---|---|
| Table (Back to File Summary) | MSPB (Hospital) |
| Description | Hospital-level Medicare Spending per Beneficiary |
| File Name | MEDICARE_HOSPITAL_SPENDING_PER_PATIENT-HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | MSPB (National) |
| Description | National-level Medicare Spending per Beneficiary |
| File Name | MEDICARE_HOSPITAL_SPENDING_PER_PATIENT-NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Measure ID |
| Char(74) | Measure Name |
| Num(8) | Score |
| Char(1) | Footnote - Score |
| Char(12) | National Median |
| Char(1) | Footnote - National Median |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | MSPB (State) |
| Description | State-level Medicare Spending per Beneficiary |
| File Name | MEDICARE_HOSPITAL_SPENDING_PER_PATIENT-STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(6) | Measure ID |
| Char(74) | Measure Name |
| Char(13) | Score |

| | |
|---|--|
| Table (Back to File Summary) | MSPB (State) |
| Description | State-level Medicare Spending per Beneficiary |
| File Name | MEDICARE_HOSPITAL_SPENDING_PER_PATIENT-STATE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | MSPB Spending by Claim |
| Description | Medicare Spending per Beneficiary breakdowns by claim type |
| File Name | MEDICARE_HOSPITAL_SPENDING_BY_CLAIM.CSV |
| Data Type | Column Name - CSV |
| Char(195) | Facility Name |
| Num(8) | Facility ID |
| Char(2) | State |
| Char(63) | Period |
| Char(25) | Claim Type |
| Num(8) | Avg Spndg Per EP Hospital |
| Num(8) | Avg Spndg Per EP State |
| Num(8) | Avg Spndg Per EP National |
| Char(6) | Percent of Spndg Hospital |
| Char(6) | Percent of Spndg State |
| Char(6) | Percent of Spndg National |
| Date | Start Date |
| Date | End Date |

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (Hospital) |
| Description | Hospital-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(72) | Facility Name |
| Char(50) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(20) | County Name |
| Char(31) | HBIPS-2 Measure Description |
| Char(13) | HBIPS-2 Overall Rate Per 1000 |
| Char(13) | HBIPS-2 Overall Num |
| Char(13) | HBIPS-2 Overall Den |
| Num(8) | HBIPS-2 Overall Footnote |
| Char(22) | HBIPS-3 Measure Description |
| Char(13) | HBIPS-3 Overall Rate Per 1000 |
| Char(13) | HBIPS-3 Overall Num |
| Char(13) | HBIPS-3 Overall Den |
| Num(8) | HBIPS-3 Overall Footnote |
| Char(88) | HBIPS-5 Measure Description |
| Char(13) | HBIPS-5 % |
| Char(13) | HBIPS-5 Denominator |
| Char(7) | HBIPS-5 Footnote |
| Char(39) | SMD Measure Description |
| Char(13) | SMD % |
| Char(13) | SMD Denominator |
| Num(8) | SMD Footnote |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (Hospital) |
| Description | Hospital-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Char(50) | SUB-2/-2a Measure Description |
| Char(13) | SUB-2 % |
| Char(13) | SUB-2 Denominator |
| Num(8) | SUB-2 Footnote |
| Char(13) | SUB-2a % |
| Char(13) | SUB-2a Denominator |
| Num(8) | SUB-2a Footnote |
| Char(78) | SUB-3/-3a Measure Description |
| Char(13) | SUB-3 % |
| Char(13) | SUB-3 Denominator |
| Num(8) | SUB-3 Footnote |
| Char(13) | SUB-3a % |
| Char(13) | SUB-3a Denominator |
| Num(8) | SUB-3a Footnote |
| Char(41) | TOB-2/-2a Measure_Desc |
| Char(13) | TOB-2 % |
| Char(13) | TOB-2 Denominator |
| Num(8) | TOB-2 Footnote |
| Char(13) | TOB-2a % |
| Char(13) | TOB-2a Denominator |
| Num(8) | TOB-2a Footnote |
| Char(54) | TOB-3/-3a Measure Description |
| Char(13) | TOB-3 % |
| Char(13) | TOB-3 Denominator |
| Num(8) | TOB-3 Footnote |
| Char(13) | TOB-3a % |
| Char(13) | TOB-3a Denominator |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (Hospital) |
| Description | Hospital-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Num(8) | TOB-3a Footnote |
| Char(79) | TR-1 Measure Description |
| Char(13) | TR-1 % |
| Char(13) | TR-1 Denominator |
| Num(8) | TR-1 Footnote |
| Char(46) | TR-2 Measure Description |
| Char(13) | TR-2 % |
| Char(13) | TR-2 Denominator |
| Num(8) | TR-2 Footnote |
| Date | Start Date |
| Date | End Date |
| Char(134) | FUH Measure Description |
| Char(13) | FUH-30 % |
| Char(13) | FUH-30 Denominator |
| Num(8) | FUH-30 Footnote |
| Char(13) | FUH-7 % |
| Char(13) | FUH-7 Denominator |
| Num(8) | FUH-7 Footnote |
| Date | FUH Measure Start Date |
| Date | FUH Measure End Date |
| Char(65) | MedCont Measure Desc |
| Char(13) | MedCont % |
| Char(13) | MedCont Denominator |
| Num(8) | MedCont Footnote |
| Date | MedCont Measure Start Date |
| Date | MedCont Measure End Date |
| Char(118) | READM-30-IPF Measure Desc |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (Hospital) |
| Description | Hospital-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Char(35) | READM-30-IPF Category |
| Char(13) | READM-30-IPF Denominator |
| Char(13) | READM-30-IPF Rate |
| Char(13) | READM-30-IPF Lower Estimate |
| Char(13) | READM-30-IPF Higher Estimate |
| Num(8) | READM-30-IPF Footnote |
| Date | READM-30-IPF Start Date |
| Date | READM-30-IPF End Date |
| Char(36) | IMM-2 Measure Description |
| Char(13) | IMM-2 % |
| Char(13) | IMM-2 Denominator |
| Num(8) | IMM-2 Footnote |
| Date | Flu Season Start Date |
| Date | Flu Season End Date |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (National) |
| Description | National-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(31) | HBIPS-2 Measure Description |
| Num(8) | N HBIPS-2 Overall Rate Per 1000 |
| Num(8) | N HBIPS-2 Overall Num |
| Num(8) | N HBIPS-2 Overall Den |
| Char(22) | HBIPS-3 Measure Description |
| Num(8) | N HBIPS-3 Overall Rate Per 1000 |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (National) |
| Description | National-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | N HBIPS-3 Overall Num |
| Num(8) | N HBIPS-3 Overall Den |
| Char(88) | HBIPS-5 Measure Description |
| Num(8) | N HBIPS-5 % |
| Num(8) | HBIPS-5 Top 10% |
| Char(39) | SMD Measure Description |
| Num(8) | N SMD % |
| Num(8) | SMD Top 10% |
| Char(50) | SUB-2/-2a Measure Description |
| Num(8) | N SUB-2 % |
| Num(8) | SUB-2 Top 10% |
| Num(8) | N SUB-2a % |
| Num(8) | SUB-2a Top 10% |
| Char(78) | SUB-3/-3a Measure Description |
| Num(8) | N SUB-3 % |
| Num(8) | SUB-3 Top 10% |
| Num(8) | N SUB-3a % |
| Num(8) | SUB-3a Top 10% |
| Char(41) | TOB-2/-2a Measure Desc |
| Num(8) | N TOB-2 % |
| Num(8) | TOB-2 Top 10% |
| Num(8) | N TOB-2a % |
| Num(8) | TOB-2a Top 10% |
| Char(54) | TOB-3/-3a Measure Description |
| Num(8) | N TOB-3 % |
| Num(8) | TOB-3 Top 10% |
| Num(8) | N TOB-3a % |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (National) |
| Description | National-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | TOB-3a Top 10% |
| Char(79) | TR-1 Measure Description |
| Num(8) | N TR-1 % |
| Num(8) | TR-1 Top 10% |
| Char(46) | TR-2 Measure Description |
| Num(8) | N TR-2 % |
| Num(8) | TR-2 Top 10% |
| Date | Start Date |
| Date | End Date |
| Char(134) | FUH Measure Description |
| Num(8) | N FUH-30 % |
| Num(8) | FUH-30 Top 10% |
| Num(8) | N FUH-7 % |
| Num(8) | FUH-7 Top 10% |
| Date | FUH Measure Start Date |
| Date | FUH Measure End Date |
| Char(65) | MedCont Measure Description |
| Num(8) | MedCont % |
| Num(8) | MedCont Top 10% |
| Date | N MedCont Measure Start Date |
| Date | N MedCont Measure End Date |
| Char(118) | READM-30-IPF Measure Desc |
| Num(8) | READM-30-IPF National Rate |
| Num(8) | N READM-30-IPF # IPFs Worse |
| Num(8) | N READM-30-IPF # IPFs Same |
| Num(8) | N READM-30-IPF # IPFs Better |
| Num(8) | N READM-30-IPF # IPFs Too Few |

| | |
|---|--|
| Table (Back to File Summary) | IPFQR (National) |
| Description | National-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Date | READM-30-IPF Start Date |
| Date | READM-30-IPF End Date |
| Char(36) | IMM-2 Measure Description |
| Num(8) | N IMM-2 % |
| Num(8) | IMM-2 Top 10% |
| Date | Flu Season Start Date |
| Date | Flu Season End Date |

| | |
|---|---|
| Table (Back to File Summary) | IPFQR (State) |
| Description | State-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(31) | HBIPS-2 Measure Description |
| Num(8) | S HBIPS-2 Overall Rate Per 1000 |
| Num(8) | S HBIPS-2 Overall Num |
| Num(8) | S HBIPS-2 Overall Den |
| Char(22) | HBIPS-3 Measure Description |
| Num(8) | S HBIPS-3 Overall Rate Per 1000 |
| Num(8) | S HBIPS-3 Overall Num |
| Num(8) | S HBIPS-3 Overall Den |
| Char(88) | HBIPS-5 Measure Description |
| Num(8) | S HBIPS-5 % |
| Char(39) | SMD Measure Description |
| Num(8) | S SMD % |

| | |
|---|---|
| Table (Back to File Summary) | IPFQR (State) |
| Description | State-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(50) | SUB-2/-2a Measure Description |
| Num(8) | S SUB-2 % |
| Num(8) | S SUB-2a % |
| Char(78) | SUB-3/-3a Measure Description |
| Num(8) | S SUB-3 % |
| Num(8) | S SUB-3a % |
| Char(41) | TOB-2/-2a Measure Desc |
| Num(8) | S TOB-2 % |
| Num(8) | S TOB-2a % |
| Char(54) | TOB-3/-3a Measure Description |
| Num(8) | S TOB-3 % |
| Num(8) | S TOB-3a % |
| Char(79) | TR-1 Measure Description |
| Num(8) | S TR-1 % |
| Char(46) | TR-2 Measure Description |
| Num(8) | S TR-2 % |
| Date | Start Date |
| Date | End Date |
| Char(134) | FUH Measure Description |
| Num(8) | S FUH-30 % |
| Num(8) | S FUH-7 % |
| Date | FUH Measure Start Date |
| Date | FUH Measure End Date |
| Char(65) | MedCont Measure Description |
| Char(13) | S MedCont % |
| Date | MedCont Measure Start Date |
| Date | MedCont Measure End Date |

| | |
|---|---|
| Table (Back to File Summary) | IPFQR (State) |
| Description | State-level results for Inpatient Psychiatric Facility Quality Reporting Program measures |
| File Name | IPFQR_QUALITYMEASURES_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(118) | READM-30-IPF Measure Desc |
| Num(8) | S READM-30-IPF # IPFs Worse |
| Num(8) | S READM-30-IPF # IPFs Same |
| Num(8) | S READM-30-IPF # IPFs Better |
| Num(8) | S READM-30-IPF # IPFs Too Few |
| Date | READM-30-IPF Start Date |
| Date | READM-30-IPF End Date |
| Char(36) | IMM-2 Measure Description |
| Num(8) | S IMM-2 % |
| Date | Flu Season Start Date |
| Date | Flu Season End Date |

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

| | |
|---|--|
| Table (Back to File Summary) | PCHQR - OCM |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program oncology care measures |
| File Name | PCH_ONCOLOGY_CARE_MEASURES_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(52) | Facility Name |
| Char(20) | Hospital Type |
| Char(24) | Address |
| Char(12) | City |
| Char(2) | State |
| Num(8) | ZIP Code |

| | |
|---|--|
| Table (Back to File Summary) | PCHQR - OCM |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program oncology care measures |
| File Name | PCH_ONCOLOGY_CARE_MEASURES_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(12) | County Name |
| Char(6) | Measure ID |
| Char(92) | Measure Description |
| Num(8) | Hospital Performance |
| Num(8) | Denominator |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | PCH - HAI |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program healthcare-associated infections measures |
| File Name | PCH_HEALTHCARE_ASSOCIATED_INFECTIONS_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(52) | Facility Name |
| Char(20) | Hospital Type |
| Char(24) | Address |
| Char(12) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(12) | County Name |
| Char(17) | Measure ID |
| Char(73) | Measure Name |
| Char(13) | Score |

| | |
|---|---|
| Table (Back to File Summary) | PCH - HAI |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program healthcare-associated infections measures |
| File Name | PCH_HEALTHCARE_ASSOCIATED_INFECTIONS_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | PCHQR - HCAHPS (Hospital) |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program for the patient experience domain measures |
| File Name | PCH_HCAHPS_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(52) | Facility Name |
| Char(24) | Address |
| Char(12) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(12) | County Name |
| Char(14) | Phone Number |
| Char(25) | HCAHPS Measure ID |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Char(14) | Patient Survey Star Rating |
| Num(8) | Patient Survey Star Rating Footnote |
| Char(14) | HCAHPS Answer Percent |
| Num(8) | HCAHPS Answer Percent Footnote |
| Char(14) | HCAHPS Linear Mean Value |

| | |
|---|--|
| Table (Back to File Summary) | PCHQR - HCAHPS (Hospital) |
| Description | Hospital-level results for PPS-Exempt Cancer Hospital Quality Reporting Program for the patient experience domain measures |
| File Name | PCH_HCAHPS_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(13) | Number of Completed Surveys |
| Num(8) | Number of Completed Surveys Footnote |
| Char(13) | Survey Response Rate Percent |
| Num(8) | Survey Response Rate Percent Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | PCHQR - HCAHPS (National) |
| Description | National-level results for PPS-Exempt Cancer Hospital Quality Reporting Program for the patient experience domain measures |
| File Name | PCH_HCAHPS_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(21) | Measure ID |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Num(8) | HCAHPS Answer Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | PCHQR - HCAHPS (State) |
| Description | State-level results for PPS-Exempt Cancer Hospital Quality Reporting Program for the patient experience domain measures |
| File Name | PCH_HCAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Char(21) | Measure ID |

| | |
|---|---|
| Table (Back to File Summary) | PCHQR - HCAHPS (State) |
| Description | State-level results for PPS-Exempt Cancer Hospital Quality Reporting Program for the patient experience domain measures |
| File Name | PCH_HCAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(138) | HCAHPS Question |
| Char(118) | HCAHPS Answer Description |
| Char(13) | HCAHPS Answer Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | PCHQR-Outcomes (Hospital) |
| Description | Hospital-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure |
| File Name | PCH_OUTCOMES_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(52) | Facility Name |
| Char(20) | Hospital Type |
| Char(24) | Address |
| Char(12) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(12) | County Name |
| Char(6) | Measure ID |
| Char(79) | Measure Description |
| Num(8) | Total Cases |
| Char(35) | Performance Category |
| Num(8) | Rate |
| Num(8) | Interval Lower Limit |
| Num(8) | Interval Upper Limit |

| | |
|---|---|
| Table (Back to File Summary) | PCHQR-Outcomes (Hospital) |
| Description | Hospital-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure |
| File Name | PCH_OUTCOMES_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(1) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | PCHQR-Outcomes (National) |
| Description | National-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure |
| File Name | PCH_OUTCOMES_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Measure ID |
| Char(79) | Measure Description |
| Num(8) | National Rate |
| Num(8) | Better |
| Num(8) | No Different |
| Num(8) | Worse |
| Num(8) | Too Small |
| Date | Start Date |
| Date | End Date |

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

| | |
|---|--|
| Table (Back to File Summary) | ASCQR (Facility) |
| Description | Health care facility-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Char(103) | Facility Name |
| Char(10) | Facility ID |
| Num(8) | NPI |
| Char(21) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Num(8) | Year |
| Char(5) | ASC-9 Rate |
| Num(8) | ASC-9 Footnote |
| Char(5) | ASC-11 Rate |
| Num(8) | ASC-11 Footnote |
| Char(4) | ASC-12 Total Cases |
| Char(35) | ASC-12 Performance Category |
| Char(4) | ASC-12 RSHV Rate |
| Char(4) | ASC-12 Interval Lower Limit |
| Char(4) | ASC-12 Interval Upper Limit |
| Num(8) | ASC-12 Footnote |
| Char(5) | ASC-13 Rate |
| Num(8) | ASC-13 Footnote |
| Char(5) | ASC-14 Rate |
| Num(8) | ASC-14 Footnote |
| Char(4) | ASC-17 Total Cases |
| Char(35) | ASC-17 Performance Category |
| Char(3) | ASC-17 RSHV Rate |
| Char(3) | ASC-17 Interval Lower Limit |

| | |
|---|--|
| Table (Back to File Summary) | ASCQR (Facility) |
| Description | Health care facility-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_FACILITY.CSV |
| Data Type | Column Name - CSV |
| Char(3) | ASC-17 Interval Upper Limit |
| Num(8) | ASC-17 Footnote |
| Char(4) | ASC-18 Total Cases |
| Char(35) | ASC-18 Performance Category |
| Char(3) | ASC-18 RSHV Rate |
| Char(3) | ASC-18 Interval Lower Limit |
| Char(4) | ASC-18 Interval Upper Limit |
| Num(8) | ASC-18 Footnote |

| | |
|---|--|
| Table (Back to File Summary) | ASCQR (National) |
| Description | National-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Year |
| Num(8) | Avg ASC-9 Nat Rate |
| Num(8) | Median ASC-9 Nat Rate |
| Num(8) | Avg ASC-11 Nat Rate |
| Num(8) | Median ASC-11 Nat Rate |
| Num(8) | ASC-12 Nat Rate |
| Num(8) | ASC-12 Better |
| Num(8) | ASC-12 No Different |
| Num(8) | ASC-12 Worse |
| Num(8) | ASC-12 Too Small |
| Num(8) | Avg ASC-13 Nat Rate |

| | |
|---|--|
| Table (Back to File Summary) | ASCQR (National) |
| Description | National-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Median ASC-13 Nat Rate |
| Num(8) | Avg ASC-14 Nat Rate |
| Num(8) | Median ASC-14 Nat Rate |
| Num(8) | ASC-17 Nat Rate |
| Num(8) | ASC-17 Better |
| Num(8) | ASC-17 No Different |
| Num(8) | ASC-17 Worse |
| Num(8) | ASC-17 Too Small |
| Num(8) | ASC-18 Nat Rate |
| Num(8) | ASC-18 Better |
| Num(8) | ASC-18 No Different |
| Num(8) | ASC-18 Worse |
| Num(8) | ASC-18 Too Small |

| | |
|---|---|
| Table (Back to File Summary) | ASCQR (State) |
| Description | State-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(2) | State |
| Num(8) | Year |
| Char(7) | Avg ASC-9 State Rate |
| Char(7) | Median ASC-9 State Rate |
| Char(7) | Avg ASC-11 State Rate |
| Char(7) | Median ASC-11 State Rate |
| Num(8) | ASC-12 Better |

| | |
|---|---|
| Table (Back to File Summary) | ASCQR (State) |
| Description | State-level results for Ambulatory Surgical Center Quality Reporting Program measures |
| File Name | ASC_STATE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | ASC-12 No Different |
| Num(8) | ASC-12 Worse |
| Num(8) | ASC-12 Too Small |
| Char(7) | Avg ASC-13 State Rate |
| Char(7) | Median ASC-13 State Rate |
| Char(7) | Avg ASC-14 State Rate |
| Char(7) | Median ASC-14 State Rate |
| Num(8) | ASC-17 Better |
| Num(8) | ASC-17 No Different |
| Num(8) | ASC-17 Worse |
| Num(8) | ASC-17 Too Small |
| Num(8) | ASC-18 Better |
| Num(8) | ASC-18 No Different |
| Num(8) | ASC-18 Worse |
| Num(8) | ASC-18 Too Small |

Outpatient and Ambulatory Surgical Center (OAS) CAHPS

Outpatient CAHPS

| | |
|---|--|
| Table (Back to File Summary) | HOPD CAHPS (Facility) |
| Description | Hospital-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_BY_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |

| | |
|---|--|
| Table (Back to File Summary) | HOPD CAHPS (Facility) |
| Description | Hospital-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_BY_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(61) | Facility Name |
| Char(39) | Address |
| Char(19) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(20) | County |
| Char(14) | Telephone |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |
| Num(8) | Facilities and staff linear mean score |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |

| | |
|---|--|
| Table (Back to File Summary) | HOPD CAHPS (Facility) |
| Description | Hospital-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_BY_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Char(3) | Footnote |
| Num(8) | Number of Sampled Patients |
| Num(8) | Number of Completed Surveys |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | HOPD CAHPS (National) |
| Description | National-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |
| Num(8) | Facilities and staff linear mean score |

| | |
|---|--|
| Table (Back to File Summary) | HOPD CAHPS (National) |
| Description | National-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Num(8) | Number of Sampled Patients |
| Num(8) | Number of Completed Surveys |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | HOPD CAHPS (State) |
| Description | State-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(45) | State |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |
| Num(8) | Facilities and staff linear mean score |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Num(8) | Number of Sampled Patients |

| | |
|---|---|
| Table (Back to File Summary) | HOPD CAHPS (State) |
| Description | State-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for hospital outpatient departments |
| File Name | OQR_OAS_CAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Number of Completed Surveys |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

Ambulatory Surgical Center CAHPS

| | |
|---|--|
| Table (Back to File Summary) | ASC CAHPS (Facility) |
| Description | Hospital-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_BY_ASC.CSV |
| Data Type | Column Name - CSV |
| Char(10) | Facility ID |
| Char(99) | Facility Name |
| Char(52) | Address |
| Char(18) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(1) | County |
| Char(14) | Telephone |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |

| | |
|---|--|
| Table (Back to File Summary) | ASC CAHPS (Facility) |
| Description | Hospital-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_BY_ASC.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facilities and staff linear mean score |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Num(8) | Footnote |
| Num(8) | Number of Sampled Patients |
| Num(8) | Number of Completed Surveys |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|--|
| Table (Back to File Summary) | ASC CAHPS (National) |
| Description | National-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |
| Num(8) | Facilities and staff linear mean score |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Num(8) | Number of Sampled Patients |
| Num(8) | Number of Completed Surveys |

| | |
|---|--|
| Table (Back to File Summary) | ASC CAHPS (National) |
| Description | National-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_NATIONAL.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | ASC CAHPS (State) |
| Description | State-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Char(45) | State |
| Num(8) | Patients who reported that staff definitely gave care in a professional way and the facility was clean |
| Num(8) | Patients who reported that staff somewhat gave care in a professional way or the facility was somewhat clean |
| Num(8) | Patients who reported that staff did not give care in a professional way or the facility was not clean |
| Num(8) | Facilities and staff linear mean score |
| Num(8) | Patients who reported that staff definitely communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff somewhat communicated about what to expect during and after the procedure |
| Num(8) | Patients who reported that staff did not communicate about what to expect during and after the procedure |
| Num(8) | Communication about your procedure linear mean score |
| Num(8) | Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |

| | |
|---|---|
| Table (Back to File Summary) | ASC CAHPS (State) |
| Description | State-level results for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems for ambulatory surgical centers |
| File Name | ASCQR_OAS_CAHPS_STATE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest) |
| Num(8) | Patients' rating of the facility linear mean score |
| Num(8) | Patients who reported YES they would DEFINITELY recommend the facility to family or friends |
| Num(8) | Patients who reported PROBABLY YES they would recommend the facility to family or friends |
| Num(8) | Patients who reported NO, they would not recommend the facility to family or friends |
| Num(8) | Patients recommending the facility linear mean score |
| Num(8) | Number of Sampled Patients |
| Num(8) | Number of Completed Surveys |
| Num(8) | Survey Response Rate Percent |
| Date | Start Date |
| Date | End Date |

OAS Footnote Crosswalk

| | |
|---|---|
| Table (Back to File Summary) | OAS (Footnotes) |
| Description | Look up table for footnote summary text for OAS files |
| File Name | OAS_CAHPS_FOOTNOTES.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Footnote Number |
| Char(174) | OAS CAHPS Footnotes |

Linking Quality to Payment

Hospital-Acquired Conditions Reduction Program (HACRP)

| | |
|---|---|
| Table (Back to File Summary) | HACRP |
| Description | Hospital-level results for Hospital-Acquired Condition Reduction Program measures |
| File Name | FY_2022_HAC_REDUCTION_PROGRAM_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(172) | Facility Name |
| Num(8) | Facility ID |
| Char(2) | State |
| Num(8) | Fiscal Year |
| Date | PSI 90 Start Date |
| Date | PSI 90 End Date |
| Char(7) | PSI 90 W Z Score |
| Num(8) | PSI 90 Footnote |
| Char(7) | CLABSI W Z Score |
| Num(8) | CLABSI Footnote |
| Char(7) | CAUTI W Z Score |
| Num(8) | CAUTI Footnote |
| Char(7) | SSI W Z Score |
| Num(8) | SSI Footnote |
| Char(7) | MRSA W Z Score |
| Num(8) | MRSA Footnote |
| Char(7) | CDI W Z Score |
| Num(8) | CDI Footnote |
| Date | HAI Measures Start Date |
| Date | HAI Measures End Date |
| Char(7) | Total HAC Score |
| Num(8) | Total HAC Footnote |

| | |
|---|---|
| Table (Back to File Summary) | HACRP |
| Description | Hospital-level results for Hospital-Acquired Condition Reduction Program measures |
| File Name | FY_2022_HAC_REDUCTION_PROGRAM_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(3) | Payment Reduction |
| Char(1) | Payment Reduction Footnote |

Hospital Readmission Reduction Program (HRRP)

| | |
|---|---|
| Table (Back to File Summary) | HRRP |
| Description | Hospital-level results for Hospital Readmissions Reduction Program measures |
| File Name | FY_2022_HOSPITAL_READMISSIONS_REDUCTION_PROGRAM_HOSPITAL.CSV |
| Data Type | Column Name - CSV |
| Char(149) | Facility Name |
| Num(8) | Facility ID |
| Char(2) | State |
| Char(22) | Measure Name |
| Char(4) | Number of Discharges |
| Num(8) | Footnote |
| Char(6) | Excess Readmission Ratio |
| Char(7) | Predicted Readmission Rate |
| Char(7) | Expected Readmission Rate |
| Char(17) | Number of Readmissions |
| Date | Start Date |
| Date | End Date |

Hospital Value-Based Purchasing (HVBP) Program

| | |
|---|--|
| Table (Back to File Summary) | HVBP - HCAHPS |
| Description | Hospital-level results on patient experience domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_PERSON_AND_COMMUNITY_ENGAGEMENT.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Fiscal Year |
| Char(8) | Facility ID |
| Char(52) | Facility Name |
| Char(42) | Address |
| Char(20) | City |
| Char(2) | State |
| Char(7) | ZIP Code |
| Char(20) | County Name |
| Char(7) | Communication with Nurses Floor |
| Char(7) | Communication with Nurses Achievement Threshold |
| Char(7) | Communication with Nurses Benchmark |
| Char(13) | Communication with Nurses Baseline Rate |
| Char(13) | Communication with Nurses Performance Rate |
| Char(14) | Communication with Nurses Achievement Points |
| Char(13) | Communication with Nurses Improvement Points |
| Char(14) | Communication with Nurses Dimension Score |
| Char(7) | Communication with Doctors Floor |
| Char(7) | Communication with Doctors Achievement Threshold |
| Char(7) | Communication with Doctors Benchmark |
| Char(13) | Communication with Doctors Baseline Rate |
| Char(13) | Communication with Doctors Performance Rate |
| Char(14) | Communication with Doctors Achievement Points |
| Char(13) | Communication with Doctors Improvement Points |
| Char(14) | Communication with Doctors Dimension Score |

| | |
|---|--|
| Table (Back to File Summary) | HVBP - HCAHPS |
| Description | Hospital-level results on patient experience domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_PERSON_AND_COMMUNITY_ENGAGEMENT.CSV |
| Data Type | Column Name - CSV |
| Char(7) | Responsiveness of Hospital Staff Floor |
| Char(7) | Responsiveness of Hospital Staff Achievement Threshold |
| Char(7) | Responsiveness of Hospital Staff Benchmark |
| Char(13) | Responsiveness of Hospital Staff Baseline Rate |
| Char(13) | Responsiveness of Hospital Staff Performance Rate |
| Char(14) | Responsiveness of Hospital Staff Achievement Points |
| Char(13) | Responsiveness of Hospital Staff Improvement Points |
| Char(14) | Responsiveness of Hospital Staff Dimension Score |
| Char(6) | Care Transition Floor |
| Char(7) | Care Transition Achievement Threshold |
| Char(7) | Care Transition Benchmark |
| Char(13) | Care Transition Baseline Rate |
| Char(13) | Care Transition Performance Rate |
| Char(14) | Care Transition Achievement Points |
| Char(13) | Care Transition Improvement Points |
| Char(14) | Care Transition Dimension Score |
| Char(7) | Communication About Medicines Floor |
| Char(7) | Communication About Medicines Achievement Threshold |
| Char(7) | Communication About Medicines Benchmark |
| Char(13) | Communication About Medicines Baseline Rate |
| Char(13) | Communication About Medicines Performance Rate |
| Char(14) | Communication About Medicines Achievement Points |
| Char(13) | Communication About Medicines Improvement Points |
| Char(14) | Communication About Medicines Dimension Score |
| Char(7) | Cleanliness and Quietness of Hospital Environment Floor |

| | |
|---|--|
| Table (Back to File Summary) | HVBP - HCAHPS |
| Description | Hospital-level results on patient experience domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_PERSON_AND_COMMUNITY_ENGAGEMENT.CSV |
| Data Type | Column Name - CSV |
| Char(7) | Cleanliness and Quietness of Hospital Environment Achievement Threshold |
| Char(7) | Cleanliness and Quietness of Hospital Environment Benchmark |
| Char(13) | Cleanliness and Quietness of Hospital Environment Baseline Rate |
| Char(13) | Cleanliness and Quietness of Hospital Environment Performance Rate |
| Char(14) | Cleanliness and Quietness of Hospital Environment Achievement Points |
| Char(13) | Cleanliness and Quietness of Hospital Environment Improvement Points |
| Char(14) | Cleanliness and Quietness of Hospital Environment Dimension Score |
| Char(7) | Discharge Information Floor |
| Char(7) | Discharge Information Achievement Threshold |
| Char(7) | Discharge Information Benchmark |
| Char(13) | Discharge Information Baseline Rate |
| Char(13) | Discharge Information Performance Rate |
| Char(14) | Discharge Information Achievement Points |
| Char(13) | Discharge Information Improvement Points |
| Char(14) | Discharge Information Dimension Score |
| Char(7) | Overall Rating of Hospital Floor |
| Char(7) | Overall Rating of Hospital Achievement Threshold |
| Char(7) | Overall Rating of Hospital Benchmark |
| Char(13) | Overall Rating of Hospital Baseline Rate |
| Char(13) | Overall Rating of Hospital Performance Rate |
| Char(14) | Overall Rating of Hospital Achievement Points |

| | |
|---|--|
| Table (Back to File Summary) | HVBP - HCAHPS |
| Description | Hospital-level results on patient experience domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_PERSON_AND_COMMUNITY_ENGAGEMENT.CSV |
| Data Type | Column Name - CSV |
| Char(13) | Overall Rating of Hospital Improvement Points |
| Char(14) | Overall Rating of Hospital Dimension Score |
| Char(13) | HCAHPS Base Score |
| Char(13) | HCAHPS Consistency Score |

| | |
|---|---|
| Table (Back to File Summary) | HVBP - Clinical Outcomes |
| Description | Hospital-level results on outcome domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_CLINICAL_OUTCOMES.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Fiscal Year |
| Char(8) | Facility ID |
| Char(52) | Facility Name |
| Char(42) | Address |
| Char(20) | City |
| Char(2) | State |
| Char(7) | ZIP Code |
| Char(20) | County Name |
| Char(10) | MORT-30-AMI Achievement Threshold |
| Char(10) | MORT-30-AMI Benchmark |
| Char(13) | MORT-30-AMI Baseline Rate |
| Char(13) | MORT-30-AMI Performance Rate |
| Char(14) | MORT-30-AMI Achievement Points |
| Char(13) | MORT-30-AMI Improvement Points |
| Char(14) | MORT-30-AMI Measure Score |
| Char(10) | MORT-30-COPD Achievement Threshold |

| | |
|---|---|
| Table (Back to File Summary) | HVBP - Clinical Outcomes |
| Description | Hospital-level results on outcome domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_CLINICAL_OUTCOMES.CSV |
| Data Type | Column Name - CSV |
| Char(10) | MORT-30-COPD Benchmark |
| Char(13) | MORT-30-COPD Baseline Rate |
| Char(13) | MORT-30-COPD Performance Rate |
| Char(14) | MORT-30-COPD Achievement Points |
| Char(13) | MORT-30-COPD Improvement Points |
| Char(14) | MORT-30-COPD Measure Score |
| Char(10) | MORT-30-HF Achievement Threshold |
| Char(10) | MORT-30-HF Benchmark |
| Char(13) | MORT-30-HF Baseline Rate |
| Char(13) | MORT-30-HF Performance Rate |
| Char(14) | MORT-30-HF Achievement Points |
| Char(13) | MORT-30-HF Improvement Points |
| Char(14) | MORT-30-HF Measure Score |
| Char(10) | MORT-30-PN Achievement Threshold |
| Char(10) | MORT-30-PN Benchmark |
| Char(13) | MORT-30-PN Baseline Rate |
| Char(13) | MORT-30-PN Performance Rate |
| Char(14) | MORT-30-PN Achievement Points |
| Char(13) | MORT-30-PN Improvement Points |
| Char(14) | MORT-30-PN Measure Score |
| Char(10) | COMP-HIP-KNEE Achievement Threshold |
| Char(10) | COMP-HIP-KNEE Benchmark |
| Char(13) | COMP-HIP-KNEE Baseline Rate |
| Char(13) | COMP-HIP-KNEE Performance Rate |
| Char(14) | COMP-HIP-KNEE Achievement Points |
| Char(13) | COMP-HIP-KNEE Improvement Points |
| Char(14) | COMP-HIP-KNEE Measure Score |

| | |
|---|---|
| Table (Back to File Summary) | HVBP - Safety |
| Description | Hospital-level results on patient safety indicators and healthcare-associated infections measures for Hospital Value-Based Purchasing |
| File Name | HVBP_SAFETY.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Fiscal Year |
| Char(8) | Facility ID |
| Char(52) | Facility Name |
| Char(42) | Address |
| Char(20) | City |
| Char(2) | State |
| Char(7) | ZIP Code |
| Char(20) | County Name |
| Char(7) | HAI-1 Achievement Threshold |
| Char(7) | HAI-1 Benchmark |
| Char(13) | HAI-1 Baseline Rate |
| Char(13) | HAI-1 Performance Rate |
| Char(14) | HAI-1 Achievement Points |
| Char(13) | HAI-1 Improvement Points |
| Char(14) | HAI-1 Measure Score |
| Char(7) | HAI-2 Achievement Threshold |
| Char(7) | HAI-2 Benchmark |
| Char(13) | HAI-2 Baseline Rate |
| Char(13) | HAI-2 Performance Rate |
| Char(14) | HAI-2 Achievement Points |
| Char(13) | HAI-2 Improvement Points |
| Char(14) | HAI-2 Measure Score |
| Char(14) | Combined SSI Measure Score |
| Char(7) | HAI-3 Achievement Threshold |
| Char(7) | HAI-3 Benchmark |

| | |
|---|---|
| Table (Back to File Summary) | HVBP - Safety |
| Description | Hospital-level results on patient safety indicators and healthcare-associated infections measures for Hospital Value-Based Purchasing |
| File Name | HVBP_SAFETY.CSV |
| Data Type | Column Name - CSV |
| Char(13) | HAI-3 Baseline Rate |
| Char(13) | HAI-3 Performance Rate |
| Char(14) | HAI-3 Achievement Points |
| Char(13) | HAI-3 Improvement Points |
| Char(14) | HAI-3 Measure Score |
| Char(7) | HAI-4 Achievement Threshold |
| Char(7) | HAI-4 Benchmark |
| Char(13) | HAI-4 Baseline Rate |
| Char(13) | HAI-4 Performance Rate |
| Char(14) | HAI-4 Achievement Points |
| Char(13) | HAI-4 Improvement Points |
| Char(14) | HAI-4 Measure Score |
| Char(7) | HAI-5 Achievement Threshold |
| Char(7) | HAI-5 Benchmark |
| Char(13) | HAI-5 Baseline Rate |
| Char(13) | HAI-5 Performance Rate |
| Char(14) | HAI-5 Achievement Points |
| Char(13) | HAI-5 Improvement Points |
| Char(14) | HAI-5 Measure Score |
| Char(7) | HAI-6 Achievement Threshold |
| Char(7) | HAI-6 Benchmark |
| Char(13) | HAI-6 Baseline Rate |
| Char(13) | HAI-6 Performance Rate |
| Char(14) | HAI-6 Achievement Points |
| Char(13) | HAI-6 Improvement Points |
| Char(14) | HAI-6 Measure Score |

| | |
|--|--|
| Table (Back to File Summary) | HVBP - TPS |
| Description | Hospital-level total performance score for Hospital Value-Based Purchasing |
| File Name | HVBP_TPS.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Fiscal Year |
| Char(8) | Facility ID |
| Char(52) | Facility Name |
| Char(42) | Address |
| Char(20) | City |
| Char(2) | State |
| Char(7) | ZIP Code |
| Char(20) | County Name |
| Char(18) | Unweighted Normalized Clinical Outcomes Domain Score |
| Char(17) | Weighted Normalized Clinical Outcomes Domain Score |
| Char(18) | Unweighted Person and Community Engagement Domain Score |
| Char(17) | Weighted Person and Community Engagement Domain Score |
| Char(18) | Unweighted Normalized Safety Domain Score |
| Char(17) | Weighted Safety Domain Score |
| Char(18) | Unweighted Normalized Efficiency and Cost Reduction Domain Score |
| Char(17) | Weighted Efficiency and Cost Reduction Domain Score |
| Char(17) | Total Performance Score |

| | |
|---|--|
| Table (Back to File Summary) | HVBP - Efficiency |
| Description | Hospital-level results on efficiency domain measures for Hospital Value-Based Purchasing |
| File Name | HVBP_EFFICIENCY_AND_COST_REDUCTION.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Fiscal Year |
| Char(8) | Facility ID |
| Char(52) | Facility Name |
| Char(42) | Address |
| Char(20) | City |
| Char(2) | State |
| Char(7) | ZIP Code |
| Char(20) | County Name |
| Char(10) | MSPB-1 Achievement Threshold |
| Char(10) | MSPB-1 Benchmark |
| Char(13) | MSPB-1 Baseline Rate |
| Char(13) | MSPB-1 Performance Rate |
| Char(14) | MSPB-1 Achievement Points |
| Char(13) | MSPB-1 Improvement Points |
| Char(14) | MSPB-1 Measure Score |

HVBP Program Incentive Payment Adjustments

| | |
|---|---|
| Table (Back to File Summary) | HVBP FY 2018 Distribution of Net Change |
| Description | Distribution of net change in base operating diagnosis-related group payment amount |
| File Name | FY2019_DISTRIBUTION_OF_NET_CHANGE_IN_BASE_O P_DRG_PAYMENT_AMT.CSV |
| Data Type | Column Name - CSV |
| Char(4) | Percentile |
| Char(14) | Net Change in Base Operating DRG Payment Amount |

| | |
|---|---|
| Table (Back to File Summary) | HVBP FY 2018 Incentive Payment |
| Description | Value-based incentive payment amount |
| File Name | FY2019_VALUE_BASED_INCENTIVE_PAYMENT_AMO UNT.CSV |
| Data Type | Column Name - CSV |
| Char(83) | Incentive Payment Range |
| Num(8) | Number of Hospitals Receiving this Range |

| | |
|---|---|
| Table (Back to File Summary) | HVBP FY 2018 Net Change |
| Description | Net change in base operating diagnosis-related group payment amount |
| File Name | FY2019_NET_CHANGE_IN_BASE_OP_DRG_PAYMENT_ AMT.CSV |
| Data Type | Column Name - CSV |
| Char(24) | Net Change in Base Operating DRG Payment Amount |
| Num(8) | Number of Hospitals Receiving this Range |

| | |
|---|---|
| Table (Back to File Summary) | HVBP FY 2018 Percent Change |
| Description | Percent change in base operating diagnosis-related group payment amount |
| File Name | FY2019_PERCENT_CHANGE_IN_MEDICARE_PAYMENT S.CSV |
| Data Type | Column Name - CSV |
| Char(16) | % Change in Base Operating DRG Payment Amount |
| Num(8) | Number of Hospitals Receiving this % Change |

Comprehensive Care for Joint Replacement (CJR) Model

| | |
|---|---|
| Table (Back to File Summary) | Comprehensive Care for Joint Replacement (CJR) Model |
| Description | Complication rate for hip/knee replacement patients and HCAHPS linear mean roll-up score. |
| File Name | CJR_PY5_QUALITY_REPORTING_JULY_2021_PRODUCTION_FILE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | Facility ID |
| Char(57) | Facility Name |
| Num(8) | MSA |
| Char(48) | MSA Title |
| Char(5) | HCAHPS HLMR |
| Char(4) | HCAHPS HLMR Percentile |
| Date | HCAHPS Start Date |
| Date | HCAHPS End Date |
| Char(3) | HCAHPS Footnote |
| Char(7) | COMP-HIP-KNEE |
| Char(4) | COMP-HIP-KNEE Percentile |
| Date | COMP Start Date |
| Date | COMP End Date |
| Num(8) | COMP Footnote |
| Char(1) | PRO |
| Date | PRO Start Date |
| Date | PRO End Date |
| Char(2) | Reconciliation Footnote |

Veterans Health Administration Hospital Data

| | |
|---|---|
| Table (Back to File Summary) | VA - Hospital General Information |
| Description | General information on Veterans Health Administration hospitals |
| File Name | VETERANS_HEALTH_ADMINISTRATION_PROVIDER_LEVEL_DATA.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(71) | Facility Name |
| Char(40) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(15) | County Name |
| Char(14) | Phone Number |
| Char(36) | Hospital Type |
| Char(30) | Hospital Ownership |
| Char(3) | Emergency Services |
| Char(13) | Hospital overall rating |
| Num(8) | Hospital overall rating footnote |

| | |
|---|---|
| Table (Back to File Summary) | VA - Timely and Effective Care |
| Description | Veterans Health Administration hospital-level data for timely and effective care measures |
| File Name | VA_TE.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(71) | Facility Name |
| Char(40) | Address |
| Char(20) | City |
| Char(2) | State |

| | |
|---|---|
| Table (Back to File Summary) | VA - Timely and Effective Care |
| Description | Veterans Health Administration hospital-level data for timely and effective care measures |
| File Name | VA_TE.CSV |
| Data Type | Column Name - CSV |
| Num(8) | ZIP Code |
| Char(15) | County Name |
| Char(14) | Phone Number |
| Char(26) | Condition |
| Char(6) | Measure ID |
| Char(78) | Measure Name |
| Char(10) | STTag |
| Char(13) | Score |
| Char(13) | Sample |
| Char(7) | Footnote |
| Date | Start Date |
| Date | End Date |

| | |
|---|---|
| Table (Back to File Summary) | VA - IPF |
| Description | Veterans Health Administration hospital-level data for behavioral health measures |
| File Name | VA_IPF.CSV |
| Data Type | Column Name - CSV |
| Char(6) | Facility ID |
| Char(71) | Facility Name |
| Char(40) | Address |
| Char(20) | City |
| Char(2) | State |
| Num(8) | ZIP Code |
| Char(15) | County Name |
| Char(14) | Phone Number |

| | |
|---|---|
| Table (Back to File Summary) | VA - IPF |
| Description | Veterans Health Administration hospital-level data for behavioral health measures |
| File Name | VA_IPF.CSV |
| Data Type | Column Name - CSV |
| Char(39) | Condition |
| Char(7) | Measure ID |
| Char(78) | Measure Name |
| Char(13) | Score |
| Char(13) | Sample |
| Char(10) | Footnote |
| Date | Start Date |
| Date | End Date |

Appendix A – Hospital Care Compare Measures

The following crosswalk contains a listing of all measures located at the hospital-level files of the Downloadable Databases CSV Flat Files – Revised. The tables below display the locations of each measure within the CSV files, including an HVBP file directory:

Hospital_General_Information.csv

| Measure ID | Measure Name |
|---|---|
| Meets criteria for promoting interoperability of EHRs | Meets criteria for promoting interoperability |
| Hospital Overall Rating | Overall Rating |
| MORT group measure count | Count of measures included in the Mortality measure group |
| Count of facility MORT measures | Number of Mortality measures used in the hospital's overall star rating |
| Count of MORT measures better | Number of Mortality measures that are better than the national value |
| Count of MORT measures no different | Number of Mortality measures that are no different than the national value |
| Count of MORT measures worse | Number of Mortality measures that are worse than the national value |
| Safety group measure count | Count of measures included in the Safety of Care measure group |
| Count of facility Safety measures | Number of Safety of care measures used in the hospital's overall star rating |
| Count of Safety measures better | Number of Safety of care measures that are better than the national value |
| Count of Safety measures no different | Number of Safety of care measures that are no different than the national value |
| Count of Safety measures worse | Number of Safety of care measures that are worse than the national value |
| READM group measure count | Count of measures included in the Readmission measure group |
| Count of facility READM measures | Number of Readmission measures used in the hospital's overall star rating |
| Count of READM measures better | Number of Readmission measures that are better than the national value |
| Count of READM measures no different | Number of Readmission measures that are no different than the national value |
| Count of READM measures worse | Number of Readmission measures that are worse than the national value |
| Pt Exp group measure count | Count of measures included in the Patient experience measure group |
| Count of facility Pt Exp measures | Number of Patient experience measures used in the hospital's overall star rating |
| TE group measure count | Count of measures included in the Timely and effective care measure group |
| Count of facility TE measures | Number of Timely and effective care measures used in the hospital's overall star rating |

HCAHPS–Hospital.csv

| Measure ID | Measure Name |
|-------------------------|--|
| H-CLEAN-HSP-A-P | Patients who reported that their room and bathroom were "Always" clean |
| H-CLEAN-HSP-SN-P | Patients who reported that their room and bathroom were "Sometimes" or "Never" clean |
| H-CLEAN-HSP-U-P | Patients who reported that their room and bathroom were "Usually" clean |
| H-CLEAN-HSP-STAR-RATING | Cleanliness - star rating |
| H_CLEAN_LINEAR_SCORE | Cleanliness - linear mean score |
| H-COMP-1-A-P | Patients who reported that their nurses "Always" communicated well |
| H-COMP-1-SN-P | Patients who reported that their nurses "Sometimes" or "Never" communicated well |
| H-COMP-1-U-P | Patients who reported that their nurses "Usually" communicated well |
| H-COMP-1-STAR-RATING | Nurse communication - star rating |
| H_COMP_1_LINEAR_SCORE | Nurse communication - linear mean score |
| H-COMP-2-A-P | Patients who reported that their doctors "Always" communicated well |
| H-COMP-2-SN-P | Patients who reported that their doctors "Sometimes" or "Never" communicated well |
| H-COMP-2-U-P | Patients who reported that their doctors "Usually" communicated well |

| Measure ID | Measure Name |
|---------------------------|---|
| H-COMP-2-STAR-RATING | Doctor communication - star rating |
| H_COMP_2_LINEAR_SCORE | Doctor communication - linear mean score |
| H-COMP-3-A-P | Patients who reported that they "Always" received help as soon as they wanted |
| H-COMP-3-SN-P | Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted |
| H-COMP-3-U-P | Patients who reported that they "Usually" received help as soon as they wanted |
| H-COMP-3-STAR-RATING | Staff responsiveness - star rating |
| H_COMP_3_LINEAR_SCORE | Staff responsiveness - linear mean score |
| H-COMP-5-A-P | Patients who reported that staff "Always" explained about medicines before giving it to them |
| H-COMP-5-SN-P | Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them |
| H-COMP-5-U-P | Patients who reported that staff "Usually" explained about medicines before giving it to them |
| H-COMP-5-STAR-RATING | Communication about medicine - star rating |
| H_COMP_5_LINEAR_SCORE | Communication about medicines - linear mean score |
| H-COMP-6-N-P | Patients who reported that NO, they were not given information about what to do during their recovery at home |
| H-COMP-6-Y-P | Patients who reported that YES, they were given information about what to do during their recovery at home |
| H-COMP-6-STAR-RATING | Discharge information - star rating |
| H_COMP_6_LINEAR_SCORE | Discharge information - linear mean score |
| H-COMP-7-A | Patients who "Agree" they understood their care when they left the hospital |
| H-COMP-7-D-SD | Patients who "Disagree" or "Strongly Disagree" that they understood their care when they left the hospital |
| H-COMP-7-SA | Patients who "Strongly Agree" that they understood their care when they left the hospital |
| H-COMP-7-STAR-RATING | Care transition - star rating |
| H_COMP_7_LINEAR_SCORE | Care transition - linear mean score |
| H-HSP-RATING-0-6 | Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-7-8 | Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-9-10 | Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-STAR-RATING | Overall rating of hospital - star rating |
| H_HSP_RATING_LINEAR_SCORE | Overall hospital rating - linear mean score |
| H-QUIET-HSP-A-P | Patients who reported that the area around their room was "Always" quiet at night |
| H-QUIET-HSP-SN-P | Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night |
| H-QUIET-HSP-U-P | Patients who reported that the area around their room was "Usually" quiet at night |
| H-QUIET-HSP-STAR-RATING | Quietness - star rating |
| H_QUIET_LINEAR_SCORE | Quietness - linear mean score |
| H-RECMND-DN | Patients who reported NO, they would probably not or definitely not recommend the hospital |
| H-RECMND-DY | Patients who reported YES, they would definitely recommend the hospital |
| H-RECMND-PY | Patients who reported YES, they would probably recommend the hospital |

| Measure ID | Measure Name |
|-----------------------|--|
| H-RECMND-STAR-RATING | Recommend hospital - star rating |
| H_RECMND_LINEAR_SCORE | Recommend hospital - linear mean score |
| H-STAR-RATING | Summary star rating |

Timely_and_Effective_Care–Hospital.csv

| Measure ID | Measure Name |
|-------------|--|
| EDV | Emergency department volume (alternate Measure ID: EDV-1) |
| IMM-3 | Healthcare workers given influenza vaccination (alternate Measure ID: IMM-3) |
| OP-2 | Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival |
| OP-3b | Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital |
| OP-18b | Average (median) time patients spent in the emergency department before leaving from the visit (alternate Measure ID: OP-18) |
| OP-18c | Average time patients spent in the emergency department before being sent home (Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients) *This measure is only found in the downloadable database, it is not displayed on Hospital Care Compare |
| OP-22 | Percentage of patients who left the emergency department before being seen |
| OP-23 | Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival |
| OP-29 | Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy |
| OP-31 | Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery |
| SEP-1 | Severe Sepsis and Septic Shock |
| SEP-SH-3HR | Septic Shock 3 Hour |
| SEP-SH-6HR | Septic Shock 6 Hour |
| SEV-SEP-3HR | Severe Sepsis 3 Hour |
| SEV-SEP-6HR | Severe Sepsis 6 Hour |
| | |

Complications_and_Deaths–Hospital.csv

| Measure ID | Measure Name |
|---------------|--|
| COMP-HIP-KNEE | Rate of complications for hip/knee replacement patients |
| PSI 90 | Serious complications (this is a composite or summary measure; alternate Measure ID: PSI-90-SAFETY) |
| PSI 03 | Pressure sores (alternate Measure ID: PSI_3_Ulcer) |
| PSI 04 | Deaths among patients with serious treatable complications after surgery (alternate Measure ID: PSI-4-SURG-COMP) |
| PSI 06 | Collapsed lung due to medical treatment (alternate Measure ID: PSI-6-IAT-PTX) |
| PSI 08 | Broken hip from a fall after surgery (alternate Measure ID: PSI_8_POST_HIP) |
| PSI 09 | Bleeding or bruising during surgery (alternate Measure ID: PSI_9_POST_HEM) |
| PSI 10 | Kidney and diabetic complications after surgery (alternate Measure ID: PSI_10_POST_KIDNEY) |
| PSI 11 | Respiratory failure after surgery (alternate Measure ID: PSI_11_POST_RESP) |
| PSI 12 | Serious blood clots after surgery (alternate Measure ID: PSI-12-POSTOP-PULMEMB-DVT) |
| PSI 13 | Blood stream infection after surgery (alternate Measure ID: PSI_13_POST_SEPSIS) |
| PSI 14 | A wound that splits open after surgery on the abdomen or pelvis (alternate Measure ID: PSI-14-POSTOP-DEHIS) |
| PSI 15 | Accidental cuts and tears from medical treatment (alternate Measure ID: PSI-15-ACC-LAC) |
| MORT-30-AMI | Death rate for heart attack patients |

| Measure ID | Measure Name |
|--------------|--|
| MORT-30-CABG | Death rate for Coronary Artery Bypass Graft (CABG) surgery patients |
| MORT-30-COPD | Death rate for chronic obstructive pulmonary disease (COPD) patients |
| MORT-30-HF | Death rate for heart failure patients |
| MORT-30-PN | Death rate for pneumonia patients |
| MORT-30-STK | Death rate for stroke patients |

CMS_PSI_6_decimal_file.csv

| Measure ID | Measure Name |
|------------|---|
| PSI 90 | Serious complications (this is a composite or summary measure; alternate Measure ID: PSI-90-SAFETY) |
| PSI 03 | Pressure sores (alternate Measure ID: PSI_3_Ulcer) |
| PSI 06 | Collapsed lung due to medical treatment (alternate Measure ID: PSI-6-IAT-PTX) |
| PSI 08 | Broken hip from a fall after surgery (alternate Measure ID: PSI_8_POST_HIP) |
| PSI 09 | Bleeding or bruising during surgery (alternate Measure ID: PSI_9_POST_HEM) |
| PSI 10 | Kidney and diabetic complications after surgery (alternate Measure ID: PSI_10_POST_KIDNEY) |
| PSI 11 | Respiratory failure after surgery (alternate Measure ID: PSI_11_POST_RESP) |
| PSI 12 | Serious blood clots after surgery (alternate Measure ID: PSI-12-POSTOP-PULMEMB-DVT) |
| PSI 13 | Blood stream infection after surgery (alternate Measure ID: PSI_13_POST_SEPSIS) |
| PSI 14 | A wound that splits open after surgery on the abdomen or pelvis (alternate Measure ID: PSI-14-POSTOP-DEHIS) |
| PSI 15 | Accidental cuts and tears from medical treatment (alternate Measure ID: PSI-15-ACC-LAC) |

Healthcare_Associated_Infections-Hospital.csv

| Measure ID | Measure Name |
|------------|--|
| HAI-1 | Central line-associated bloodstream infections (CLABSI) in ICUs and select wards (alternate Measure ID: HAI_1_SIR) |
| HAI-2 | Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards (alternate Measure ID: HAI_2_SIR) |
| HAI-3 | Surgical Site Infection from colon surgery (SSI: Colon) (alternate Measure ID: HAI_3_SIR) |
| HAI-4 | Surgical Site Infection from abdominal hysterectomy (SSI: Hysterectomy) (alternate Measure ID: HAI_4_SIR) |
| HAI-5 | Methicillin-resistant <i>Staphylococcus aureus</i> (or MRSA) blood laboratory-identified events (bloodstream infections) (alternate Measure ID: HAI_5_SIR) |
| HAI-6 | <i>Clostridium difficile</i> (C.diff.) laboratory identified events (intestinal infections) (alternate Measure ID: HAI_6_SIR) |

Unplanned_Hospital_Visits-Hospital.csv

| Measure ID | Measure Name |
|--------------------|---|
| READM-30-AMI | Rate of readmission for heart attack patients |
| READM-30-CABG | Rate of readmission for Coronary Artery Bypass Graft (CABG) surgery patients |
| READM-30-COPD | Rate of readmission for chronic obstructive pulmonary disease (COPD) patients |
| READM-30-HF | Rate of readmission for heart failure patients |
| READM-30-HIP-KNEE | Rate of readmission after hip/knee surgery |
| READM-30-HOSP-WIDE | Rate of readmission after discharge from hospital (hospital-wide) |
| READM-30-PN | Rate of readmission for pneumonia patients |
| EDAC-30-AMI | Hospital return days for heart attack patients |
| EDAC-30-HF | Hospital return days for heart failure patients |
| EDAC-3-PN | Hospital return days for pneumonia patients |
| OP-32 | Rate of unplanned hospital visits after an outpatient colonoscopy |
| OP-35-ADM | Admissions Visits for Patients Receiving Outpatient Chemotherapy |
| OP-35-ED | Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy |

| Measure ID | Measure Name |
|------------|--|
| OP-36 | Ratio of unplanned hospital visits after hospital outpatient surgery |

Outpatient_Imaging_Efficiency–Hospital.csv

| Measure ID | Measure Name |
|------------|---|
| OP-8 | Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy |
| OP-10 | Outpatient CT scans of the abdomen that were “combination” (double) scans |
| OP-13 | Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery |

Medicare_Hospital_Spending_per_Patient–Hospital.csv

| Measure ID | Measure Name |
|------------|---|
| MSPB-1 | Spending per Hospital Patient with Medicare (Medicare Spending per Beneficiary) |

IPFQR_QualityMeasures_Facility.csv

| Measure ID | Measure Name |
|--------------|--|
| FUH-7 | Follow-up after Hospitalization for Mental Illness 7-Days *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages. |
| FUH-30 | Follow-up after Hospitalization for Mental Illness 30-Days *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages |
| HBIPS-2 | Hours of physical restraint use *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages |
| HBIPS-3 | Hours of seclusion *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages |
| HBIPS-5 | Patients discharged on multiple antipsychotic medications with appropriate justification *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages. |
| IPFQR-IMM-2 | Influenza Immunization *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages. |
| MedCont | Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were discharged and 30 days after they were discharged from the facility. |
| READM-30-IPF | Rate of readmission after discharge from hospital |
| 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 |
| SMD | Screening for Metabolic Disorders |
| TOB-2 | Tobacco Use Treatment Provided or Offered *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages. |
| TOB-2a | Tobacco Use Treatment (during the hospital stay) *This measure is found in the embedded datasets on the Inpatient Psychiatric Facility Quality Reporting webpages. |
| TOB-3 | Tobacco use treatment provided or offered at discharge |
| TOB-3a | Tobacco use treatment at discharge |
| TR1 | Transition Record with Specified Elements |
| TR2 | Timely Transmission of Transition Record |

FY_2021_HAC_Reduction_Program_Hospital.csv

| Measure ID | Measure Name |
|--------------|--|
| HACRP-D1 | Domain 1 Score |
| HACRP-PSI-90 | AHRQ PSI-90 Score (see Appendix E – Footnote Crosswalk for * definition) |
| HACRP-D2 | Domain 2 Score |
| HACRP-CLABSI | CLABSI Score (see Appendix E – Footnote Crosswalk for * definition) |
| HACRP-CAUTI | CAUTI Score |
| HACRP-SSI | SSI Score |
| HACRP-MRSA | MRSA Score |
| HACRP-CDI | CDI Score |
| HACRP-Total | Total HAC Score (see Appendix E – Footnote Crosswalk for * definition) |

FY_2021_Hospital_Readmissions_Reduction_Program_Hospital .csv

| Measure ID | Measure Name |
|------------------------|--|
| READM-30-AMI-HRRP | Excess readmission ratio for heart attack patients |
| READM-30-COPD-HRRP | Excess readmission ratio for chronic obstructive pulmonary disease (COPD) patients |
| READM-30-CABG-HRRP | Excess readmission ratio for Coronary Artery Bypass Graft (CABG) patients |
| READM-30-HF-HRRP | Excess readmission ratio for heart failure patients |
| READM-30-HIP-KNEE-HRRP | Excess readmission ratio for hip/knee replacement patients |
| READM-30-PN-HRRP | Excess readmission ratio for pneumonia patients |

PCH_OUTCOMES_HOSPITAL .csv

| Measure ID | Measure Name |
|------------|---|
| PCH-30 | Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Admission Rate |
| PCH-31 | Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Emergency Department Visits Rate |

PCH_ONCOLOGY_CARE_MEASURES_HOSPITAL .csv

| Measure ID | Measure Name |
|------------|--|
| PCH-15 | Oncology - Plan of Care for Pain – Medical Oncology and Radiation Oncology |

PCH_HCAHPS_HOSPITAL .csv

| Measure ID | Measure Name |
|--------------|--|
| Composite 1 | Communication with Nurses |
| Composite 2 | Communication with Doctors |
| Composite 3 | Responsiveness of Hospital Staff |
| Composite 5 | Communication about Medicines |
| Q8 | Cleanliness of Hospital Environment |
| Q9 | Quietness of Hospital Environment |
| Composite 6 | Discharge Information |
| Composite 7 | Care Transition |
| Q21 | Overall Rating of Hospital |
| Q22 | Willingness to Recommend this Hospital |
| Star Rating | HCAHPS Summary Star Rating |
| Linear Score | HCAHPS Linear Score for each measure |

PCH_HEALTHCARE_ASSOCIATED_INFECTIONS_HOSPITAL.csv

| Measure ID | Measure Name |
|------------|---|
| PCH-06 | Surgical Site Infection from colon surgery (SSI: Colon) |
| PCH-07 | Surgical Site Infection from abdominal hysterectomy (SSI: Hysterectomy) |
| PCH-27 | MRSA Bacteremia |
| PCH-26 | Clostridium Difficile (C.Diff) |
| PCH-28 | Influenza Vaccination Coverage Among Healthcare Personnel (HCP) |

ASC_Facility.csv

| Measure ID | Measure Name |
|------------|--|
| ASC-9 | Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients |
| ASC-11 | Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery |
| ASC-12 | Rate of unplanned hospital visits after an outpatient colonoscopy |
| ASC-13 | Normothermia |
| ASC-14 | Unplanned Anterior Vitrectomy |
| ASC-17 | Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures |
| ASC-18 | Hospital Visits after Urology Ambulatory Surgical Center Procedures |

Payment_and_Value_of_Care-Hospital.csv

| Measure ID | Measure Name |
|------------------|---|
| PAYM-30-AMI | Payment for heart attack patients |
| PAYM-30-HF | Payment for heart failure patients |
| PAYM-30-PN | Payment for pneumonia patients |
| PAYM_90_HIP_KNEE | Payment for hip/knee replacement patients |

HVBP Measures Directory

| File Name | Measure |
|--------------------------------------|--|
| hvpb_clinical_outcomes | MORT-30-AMI; MORT-30-HF; MORT-30-PN; MORT-30-COPD |
| hvpb_efficiency_and_cost_reduction | MSPB-1 |
| hvpb_person_and_community_engagement | H-COMP-1-A-P; H-COMP-2-A-P; H-COMP-3-A-P; H-COMP-5-A-P; H-COMP-6-Y-P; H-COMP-7-SA; H-HSP-RATING-9-10: H-CLEAN-QUIET-HSP-A-P |
| hvpb_safety | HAI-1; HAI-2; HAI-3; HAI-4, HAI-5, HAI-6 |
| hvpb_tps | TPS Scores (Weighted and Unweighted) for Clinical Process of Care, Patient Experience of Care, Outcome, and Efficiency Domains |

VA_TE.csv

| Measure ID | Measure Name |
|------------|---|
| EDV-1 | Emergency Department (ED) Volume |
| OP-2 | Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival |
| OP-3b | Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital |
| OP-18b | Average (median) time patients spent in the emergency department before leaving from the visit |
| OP-18c | Average time patients spent in the emergency department before being sent home |
| OP-22 | Left Without Being Seen |
| OP-23 | Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival |

VA_IPF

| Measure ID | Measure Name |
|------------|--|
| HBIPS-2 | Hours of physical restraint use |
| HBIPS-3 | Hours of seclusion |
| TOB-2 | Tobacco Use Treatment Provided or Offered |
| TOB-3 | Tobacco Use Treatment Provided or Offered at Discharge |
| SUB-2 | Alcohol Use Brief Intervention Provided or Offered |
| SUB-3 | Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge |

CJR_PY5_Quality_Reporting_July_2021_Production_File.csv

| Measure ID | Measure Name |
|-------------------|--|
| CJR-PRO | Patient reported outcomes |
| CJR HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey |
| CJR-COMP-Hip-Knee | Rate of complications for hip and knee replacement patients |

Appendix B – Measure Component Definitions

Please note, the following information is available in the *Inpatient Public Reporting Preview Help Guide* and *Outpatient Public Reporting Preview Help Guide* provided on [QualityNet.cms.gov](https://www.qualitynet.org/QualityNet.cms.gov) with each Preview Period announcement.

| Timely and Effective Care | Definition |
|---|---|
| Time-based measures (minutes) | |
| Emergency Department Volume (EDV) - Denominator | Number based on the volume of patients submitted by a hospital used for the measure OP-22: Left without Being Seen |
| Numerator | Median time |
| Denominator | Median times are identified using all cases submitted in the state that are publicly reported. Median time for the nation is based on all cases submitted in the nation. Please note that Outpatient (OP) measures only include publicly reported data. |
| Rate based measures | |
| Numerator | Score |
| Denominator | Sample; denominators greater than zero and less than 11 will not be reported on <i>Hospital Care Compare</i> . |
| Complications and Outcomes | Definition |
| Numerator | Score; the number of events (deaths, readmissions or complications) within 30 days (or other timeframes for complications) predicted based on the hospital's performance with its observed case mix. |
| Denominator | The number of outcomes expected based on the nation's performance with that hospital's case mix. |
| HAI | Definition |
| Numerator | The observed number of infections |
| Denominator | The predicted number of infections |

Appendix C – HCAHPS Survey Questions Listing

The HCAHPS survey is 29 questions in length and contains 19 substantive items that encompass critical aspects of the hospital experience, 4 screening items to skip patients to appropriate questions, and 7 demographic items that are used for adjusting the mix of patients across hospitals for analytical purposes. An overview of HCAHPS topics (6 composite topics, 2 individual topics, and 2 global topics) can be found on the [Survey of Patients' Experiences](#) webpage in the About the Data section of the Provider Data Catalog (PDC) site.

| # | Question |
|-----|---|
| Q1 | During this hospital stay, how often did nurses treat you with courtesy and respect? |
| Q2 | During this hospital stay, how often did nurses listen carefully to you? |
| Q3 | During this hospital stay, how often did nurses explain things in a way you could understand? |
| Q4 | During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? |
| Q5 | During this hospital stay, how often did doctors treat you with courtesy and respect? |
| Q6 | During this hospital stay, how often did doctors listen carefully to you? |
| Q7 | During this hospital stay, how often did doctors explain things in a way you could understand? |
| Q8 | During this hospital stay, how often were your room and bathroom kept clean? |
| Q9 | During this hospital stay, how often was the area around your room quiet at night? |
| Q11 | How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? |
| Q13 | Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? |
| Q14 | Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? |
| Q16 | During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? |
| Q17 | During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? |
| Q18 | Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? |
| Q19 | Would you recommend this hospital to your friends and family? |
| Q20 | During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. |
| Q21 | When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. |
| Q22 | When I left the hospital, I clearly understood the purpose for taking each of my medications. |

HCAHPS Star Ratings provide a quick summary of each HCAHPS measure in a format that allows consumers to more easily compare hospitals. The HCAHPS Summary Star Rating is a roll-up of all the HCAHPS Star Ratings.

HCAHPS linear mean scores are used in the construction of HCAHPS star ratings. The linear mean scores employ all survey response categories for the items in each HCAHPS measure and are converted and combined into a 0-100 linear-scaled measure score.

Additional information about [HCAHPS Star Ratings](#), including technical notes and frequently asked questions, can be found on the HCAHPS website (www.HCAHPSonline.org).

Appendix D – OAS CAHPS Survey Questions Listing

The OAS CAHPS survey includes questions about patients' experiences with their preparation for the surgery or procedure, check-in processes, cleanliness of the facility, communications with the facility staff, discharge from the facility, and preparation for recovering at home. The survey also includes questions about whether patients received information about what to do if they had possible side effects during their recovery. Survey Materials can be found at the OAS CAHPS site, in the [Survey Materials](#) page.

| # | Question |
|------|---|
| Q1 | Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure? |
| Q2 | Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure? |
| Q3 | Did the check-in process run smoothly? |
| Q4 | Was the facility clean? |
| Q5 | Were the clerks and receptionists at the facility as helpful as you thought they should be? |
| Q6 | Did the clerks and receptionists at the facility treat you with courtesy and respect? |
| Q7 | Did the doctors and nurses treat you with courtesy and respect? |
| Q8 | Did the doctors and nurses make sure you were as comfortable as possible? |
| Q9 | Did the doctors and nurses explain your procedure in a way that was easy to understand? |
| Q10 | Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia? |
| Q11 | Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand? |
| Q12 | Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand? |
| Q13* | Discharge instructions include things like symptoms you should watch for after your procedure, instructions about medicines, and home care. Before you left the facility, did you get written discharge instructions? |
| Q14* | Did your doctor or anyone from the facility prepare you for what to expect during your recovery? |
| Q15* | Some ways to control pain include prescription medicine, over-the-counter pain relievers or icepacks. Did your doctor or anyone from the facility give you information about what to do if you had pain as a result of your procedure? |
| Q16* | At any time after leaving the facility, did you have pain as a result of your procedure? |
| Q17* | Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had nausea or vomiting? |
| Q18* | At any time after leaving the facility, did you have nausea or vomiting as a result of either your procedure or the anesthesia? |
| Q19* | Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had bleeding as a result of your procedure? |
| Q20* | At any time after leaving the facility, did you have bleeding as a result of your procedure? |
| Q21* | Possible signs of infection include fever, swelling, heat, drainage or redness. Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had possible signs of infection? |
| Q22* | At any time after leaving the facility, did you have any signs of infection? |
| Q23 | Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility? |
| Q24 | Would you recommend this facility to your friends and family? |

* Composite 3, which is comprised of questions 13-22, is currently under review by CMS and not being publicly reported.

Appendix E – Footnote Crosswalk

| Public Reporting Footnote Values | | |
|----------------------------------|--|---|
| # | Text | Definition |
| 1 | The number of cases/patients is too few to report. | <p>This footnote is applied:</p> <ul style="list-style-type: none"> • When the number of cases/patients does not meet the required minimum amount for public reporting; • When the number of cases/patients is too small to reliably tell how well a hospital is performing; and/or • To protect personal health information. |
| 2 | Data submitted were based on a sample of cases/patients. | This footnote indicates that a hospital chose to submit data for a random sample of its cases/patients while following specific rules for how to select the patients. |
| 3 | Results are based on a shorter time period than required. | <p>This footnote indicates that the hospital's results were based on data from less than the maximum possible time period generally used to collect data for a measure. View the Measure Dates dataset for more information.</p> <p>This footnote is applied:</p> <ul style="list-style-type: none"> • When a hospital elected not to submit data for a measure for one or more, but not all possible quarters; • When there was no data to submit for a measure for one or more, but not all possible quarters; and/or • When a hospital did not successfully submit data for a measure for one or more, but not all possible quarters. |
| 4 | Data suppressed by CMS for one or more quarters. | The results for these measures were excluded for various reasons, such as data inaccuracies. |
| 5 | Results are not available for this reporting period. | <p>This footnote is applied:</p> <ul style="list-style-type: none"> • When a hospital elected not to submit data for the entire reporting period; or • When a hospital had no claims data for a particular measure; or • When a hospital elected to suppress a measure from being publicly reported. |
| 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. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 100. |
| 7 | No cases met the criteria for this measure. | This footnote is applied when a hospital did not have any cases meet the inclusion criteria for a measure. |
| 8 | The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero. | None |
| 9 | No data are available from the state/territory for this reporting period. | <p>This footnote is applied when:</p> <ul style="list-style-type: none"> • Too few hospitals in a state/territory had data available or • No data was reported for this state/territory. |

| Public Reporting Footnote Values | | |
|----------------------------------|--|---|
| # | Text | Definition |
| 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. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 50. |
| 11 | There were discrepancies in the data collection process. | This footnote is applied when there have been deviations from data collection protocols. CMS is working to correct this situation. |
| 12 | This measure does not apply to this hospital for this reporting period. | This footnote is applied when: <ul style="list-style-type: none"> • There were zero device days or procedures for the entire reporting period, • The hospital does not have ICU locations. • The hospital is a new member of the registry or reporting program and didn't have an opportunity to submit any cases; or • The hospital doesn't report this voluntary measure; or • Results for this VA hospital are combined with those from the VA administrative parent hospital that manages all points of service. |
| 13 | Results cannot be calculated for this reporting period. | This footnote is applied when: <ul style="list-style-type: none"> • The number of predicted infections is less than 1. • The number of observed MRSA or Clostridium difficile infections present on admission (community-onset prevalence) was above a pre-determined cut-point. |
| 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 in order to protect confidentiality. Results are combined as follows: (1) the District of Columbia and Delaware are combined; (2) Alaska and Washington are combined; (3) North Dakota and South Dakota are combined; and (4) New Hampshire and Vermont are combined. Hospitals located in Maryland and U.S. territories are excluded from the measure calculation. |
| 15 | The number of cases/patients is too few to report a star rating. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 100. In order to receive HCAHPS Star Ratings, hospitals must have at least 100 completed HCAHPS Surveys over a four-quarter period. |
| 16 | There are too few measures or measure groups reported to calculate a star rating or measure group score. | This footnote is applied when a hospital: <ul style="list-style-type: none"> • Reported data for fewer than 3 measures in any measure group used to calculate star ratings; or • Reported data for fewer than 3 of the measure groups used to calculate star ratings; or • Did not report data for at least 1 outcomes measure group. |
| 17 | This hospital's star rating only includes data reported on inpatient services. | This footnote is applied when a hospital only reports data for inpatient hospital services. |
| 18 | This result is not based on performance data; the hospital did not submit data and did not submit an HAI exemption form. | This footnote is applied when a hospital did not submit data through the National Healthcare Safety Network (NHSN) and did not have a HAI exemption on file. In such a case, the hospital receives the maximum Winsorized z-score. |
| 19 | Data are shown only for hospitals that participate in the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs. | Footnote is applied for those hospitals that do not participate in the IQR, OQR programs. |

| Public Reporting Footnote Values | | |
|----------------------------------|--|---|
| # | Text | Definition |
| 20 | State and national averages do not include Veterans Health Administration (VHA) hospital data. | Data for VHA hospitals are calculated separately from data for other inpatient acute-care hospitals. This footnote is no longer used. |
| 21 | Patient survey results for Veterans Health Administration (VHA) hospitals do not represent official HCAHPS results and are not included in state and national averages. | The VHA Survey of Healthcare Experiences of Patients (SHEP) inpatient survey uses the same questions as the HCAHPS survey but is collected and analyzed independently. This footnote is no longer used. |
| 22 | Overall star ratings are not calculated for Veterans Health Administration (VHA) or Department of Defense (DoD) hospitals. | VHA and DoD hospitals are not included in the calculations of the overall star rating. |
| 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. |
| 24 | Results for this VA hospital are combined with those from the VA administrative parent hospital that manages all points of service. | This footnote is applied to VA hospitals only. |
| 25 | State and national averages include Veterans Health Administration (VHA) hospital data. | Data for VHA hospitals are calculated along with data for other inpatient acute-care hospitals. |
| 26 | State and national averages include Department of Defense (DoD) hospital data. | Data for DoD hospitals are calculated along with data for other inpatient acute-care hospitals. |
| 27 | Patient survey results for Department of Defense (DoD) hospitals do not represent official HCAHPS results and are not included in state and national averages. | The DoD TRICARE Inpatient Satisfaction Survey (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. |
| Maryland data footnotes | | |
| * | For Maryland hospitals, no data are available to calculate a PSI 90 measure result; therefore, no performance decile or points are assigned for Domain 1 and the Total HAC score is dependent on the Domain 2 score. | None |
| ** | This value was calculated using data reported by the hospital in compliance with the requirements outlined for this program and does not take into account information that became available at a later date. | None |

| Public Reporting Footnote Values | | |
|----------------------------------|--|------------|
| # | Text | Definition |
| a | Maryland hospitals are waived from receiving payment adjustments under the Program | None |
| CJR data footnotes | | |
| * | Ineligible for reconciliation based on performance on CJR-specific quality measures | None |
| ** | Did not perform eligible CJR episodes as defined at § 510.210 of the CJR final rule | None |
| *** | Too few completed surveys or months of data to calculate HCAHPS Linear Mean Roll-up score | None |
| **** | Does not participate in the Inpatient Quality Reporting (IQR) program | None |
| OAS CAHPS data footnotes | | |
| 1 | Very few patients completed the survey. The scores shown, if any, reflect a very small number of surveys and they do not accurately tell how a facility is doing. | None |
| 2 | Survey results are based on less than 12 months of data. | None |
| 3 | Fewer than 100 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how a facility is doing. | None |
| 4 | No survey results are available for this reporting period. | None |
| 5 | There were problems with the data and they are being corrected. | None |

Appendix F – Release Updates

January 2022 Release

The following updates can be found on QualityNet.cms.gov in the “Quick Reference Guides” located in the “Public Reporting” section posted on October 19, 2021

- [Inpatient Public Reporting Preview Quick Reference Guide](#)
- [Outpatient Public Reporting Preview Quick Reference Guide](#)
- [PPS-Exempt Cancer Hospital Public Reporting Preview Quick Reference Guide](#)
- [Inpatient Psychiatric Facility Public Reporting Quick Reference Guide](#)

****Please note:** HVBP scores and payment adjustments will not be updated in the January 2022 public reporting due to impact to the data from the COVID-19 public health emergency.

****The IPFQR Measure name MedCoPsy has been renamed MedCont.**

New Measures

| Program | Update |
|---------|--|
| ASCQ | |
| ASC-17 | Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures |
| ASC-18 | Hospital Visits after Urology Ambulatory Surgical Center Procedures |

Retired Measures

| Measure ID | Measure Name |
|------------|---|
| DoD/OQR | |
| OP-33 | Percentage of patients receiving appropriate radiation therapy for cancer that has spread to the bone |
| PCHQR | PCH-25 |
| PCH-25 | External Beam Radiotherapy (EBRT) for Bone Metastases |
| VHA | |
| HBIPS-5 | Patients discharged on multiple antipsychotic medications with appropriate justification |

October 2021 Release

The following updates can be found on QualityNet.cms.gov in the “Quick Reference Guides” located in the “Public Reporting” section posted on July 14, 2021

- [Inpatient Hospital Compare Preview Quick Reference Guide](#)
- [Outpatient Quality Reporting Hospital Compare Preview Quick Reference Guide](#)
- [PPS-Exempt Cancer Hospital Quality Reporting Hospital Compare Preview Quick Reference Guide](#)

***No new or retired measures**

*** Please note the following below:**

Hospital-Specific Reports (HSRs), originally released on May 3, 2021, for the July 2021 Public Reporting preview period were re-delivered due to missing denominator exclusion codes for PSI 03.

The following is a list of all CMS Patient Safety Indicator (PSI) measures; however, only PSI 03 and PSI 90 were impacted by this issue and have corrected data.

- PSI 04 – Death Rate Among Surgical Inpatients with Serious Treatable Complications
- CMS PSI 90 – Patient Safety and Adverse Events Composite
 - PSI 03 – Pressure Ulcer Rate
 - PSI 06 – Iatrogenic Pneumothorax Rate
 - PSI 08 – In Hospital Fall with Hip Fracture
 - PSI 09 – Perioperative 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

A new 30-day Preview period was from August 18, 2021 through September 17, 2021. Please note, this second preview period focused only on those data elements directly impacted by the incomplete exclusion codes, namely PSI 03 and PSI 90 measure scores. The preview period process does not allow hospitals to submit additional corrections related to the underlying claims data or to add new claims to the data extract used to calculate the results.

Notes

- No changes were made to any of the other measures in the HSR.
- In response to the COVID-19 public health emergency, CMS will not use claims data reflecting services provided January 1, 2020–June 30, 2020 (Q1 2020 and Q2 2020) in its calculations for the Medicare quality reporting programs. Hospitals do not need to request an Extraordinary Circumstances Exception (ECE) for measures and submissions covered under the COVID-19 exception for Q1 2020 and Q2 2020.
- The PSI 90 calculations in the Hospital Acquired Condition (HAC) Reduction Program HSRs, released on August 13, 2021, use the recalculated PSI 90 results with the updated PSI 03.

July 2021 Release

Note: In response to the Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) extended many flexibilities for the Hospital Quality Reporting and Value-based Payment Programs.

Data from the 1st and 2nd quarters of 2020 are not being reported due to the impact of the COVID-19 pandemic. HCAHPS scores will not be updated in the July 2021 public reporting due to delays in the receipt of Q3 2020 data. OAS CAHPS data will include 3rd and 4th quarter 2019 data, in addition to the 3rd and 4th quarter 2020 data. For more information, please reference <https://qualitynet.cms.gov/inpatient/notifications> (2020-111-IP)

As a reminder, on March 22, 2020, CMS granted exceptions from reporting requirements and extensions for providers participating in Medicare quality reporting programs with respect to measure reporting and data submissions for programs. This announcement can be found at [cms.gov](https://www.cms.gov/newsroom) newsroom. On August 25, 2020, CMS released an Interim Final Rule with Comment Period (CMS-3401-IFC) providing further relief and clarifying that CMS will not use data from January 1, 2020 through June 30, 2020 (1Q 2020 - 2Q 2020) for performance or use in quality reporting or value-based payment programs.

The following updates can be found on [QualityNet.cms.gov](https://qualitynet.cms.gov) in the “Quick Reference Guides” located in the “Public Reporting” section posted on May 4, 2021

- [Inpatient Hospital Compare Preview Quick Reference Guide](#)
- [Outpatient Quality Reporting Hospital Compare Preview Quick Reference Guide](#)
- [PPS-Exempt Cancer Hospital Quality Reporting Hospital Compare Preview Quick Reference Guide](#)

New Measures

| Program | Update |
|------------|--|
| IQR | |
| VHA | VHA is now reporting the measures READM-HIP-KNEE and COMP-HIP-KNEE |
| DoD | DoD is now reporting measure HAI-6 |

Retired Measures

| Measure ID | Measure Name |
|-------------|--|
| ACoS | |
| ACoS | ACoS NSQIP Dataset |
| VHA | |
| VHA | VA PSI dataset will be combined with the CMS PSI dataset |
| VHA | VHA Measure dates dataset |

April 2021 Release

Note: In response to the Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) extended many flexibilities for the Hospital Quality Reporting and Value-based Payment Programs.

As a result, some quarterly refreshed measures that would have included 1st quarter and/or 2nd quarter 2020 data will not be updated in April 2021 and will continue to display the same data that was reported in October 2020 due to the COVID-19 pandemic. OAS CAHPS data will include 3rd and 4th quarter 2019 data, in addition to the 3rd and 4th quarter 2020 data. ACoS data will continue to display the same data that was reported in October 2020. For more information, please reference <https://qualitynet.cms.gov/inpatient/notifications> (2020-111-IP)

As a reminder, on March 22, 2020, CMS granted exceptions from reporting requirements and extensions for providers participating in Medicare quality reporting programs with respect to measure reporting and data submissions for programs. This announcement can be found at [cms.gov](https://www.cms.gov/newsroom) newsroom. On August 25, 2020, CMS released an Interim Final Rule with Comment Period (CMS-3401-IFC) providing further relief and clarifying that CMS will not use data from January 1, 2020 through June 30, 2020 (1Q 2020 - 2Q 2020) for performance or use in quality reporting or value-based payment programs.

The following updates can be found on [QualityNet.cms.gov](https://qualitynet.cms.gov) in the “Quick Reference Guides” located in the “Public Reporting” section posted on January 27, 2021.

- [Inpatient Public Reporting Preview Quick Reference Guide](#)
- [Outpatient Public Reporting Preview Quick Reference Guide](#)
- [PPS-Exempt Cancer Hospital Quality Reporting Program Public Reporting Preview Quick Reference Guide](#)

***No new or retired measures**

New Measures

| Program | Update |
|------------|---|
| IQR | |
| DoD | DoD is now reporting measures OP-22 and SEP-1 |
| HVBP | HVBP is now reporting measure MORT-30-COPD |
| IPFQR | IPFQR is now reporting MedCoPsy - Medication Continuation Following Inpatient Psychiatric Discharge - 3Q 2017 - 2Q 2019 |
| VHA | VHA is now reporting measures TOB-3, EDV-1 and OP-22 |

Retired Measures

| Measure ID | Measure Name |
|-------------|--|
| IQR | |
| ED-2b | Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room (alternate Measure ID: ED-2) |
| OQR | |
| OP-30 | Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe |
| OP-12 | Able to receive lab results electronically (HIT measure) |
| OP-17 | Able to track patients' lab results, tests, and referrals electronically between visits (HIT measure) |
| DoD | |
| ED-2b | Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room (alternate Measure ID: ED-2) |
| OP-30 | Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe |
| HVBP | |
| PC-01 | Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary |
| PCH | |
| PCH-14 | Oncology - Radiation Dose Limits to Normal Tissues |
| PCH-16 | Oncology - Medical and Radiation - Pain Intensity Quantified |
| PCH-17 | Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients |
| PCH-18 | Avoidance of Overuse Measure - Bone Scan for Staging Low Risk Prostate Cancer Patients |
| VHA | |
| ED-2b | Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room (alternate Measure ID: ED-2) |