System Requirements Specification

Hospital Downloadable Database Data Dictionary

Centers for Medicare & Medicaid Services

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

Table of Contents

Introduction

Care Compare on Medicare.gov 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. Care Compare on Medicare.gov allows consumers to select up to three 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 website to better inform health care consumers about a hospital's quality of care. CMS 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 Defense (DoD) and hospital outpatient departments. Care Compare on Medicare.gov 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 public reporting can be found by visiting the CMS.gov website and performing a search for Hospital Quality Initiative Public Reporting. To access the Care Compare on Medicare.gov website, please visit Medicare.gov/care-compare.

Hospital Quality Initiative Public Reporting websites are 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 (PDC) on Medicare.gov 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 Quality Initiative Public Reporting websites are publicly accessible. As works of the U.S. government, public reporting 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 Quality Initiatives Public Reporting 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:

- 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	*Clostridium difficile* Infection
CEBP	Clinical Episode Based Purchasing
CEHRT	Certified Electronic Health Record Technology
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
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EDAC	Excess days in acute care
FAPH	Follow-up after psychiatric hospitalization
FTNT	Footnote
GMCS	Global Malnutrition Composite Score
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
HH	Hospital Harm
HIP-KNEE	Total Hip/Knee Arthroplasty
HIT	Health Information Technology
HRRP	Hospital Readmissions Reduction Program
HVBP	Hospital Value-Based Purchasing
HWM	Hospital Wide Mortality
HWR	Hospital Wide Readmissions
IMG	Imaging
IMM	Immunization
IPFQR	Inpatient Psychiatric Facility Quality Reporting
IQR	Inpatient Quality Reporting
MORT	Mortality
MRSA	Methicillin-Resistant *Staphylococcus aureus*
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

ORAE	Opioid-Related Adverse Events
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
PDC	Provider Data Catalog
PI	Promoting Interoperability
PN	Pneumonia
PRO	Patient reported outcomes
PSI	Patient Safety Indicators
READM	Readmissions
REH	Rural Emergency Hospital
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
VA	Veterans Administration
VHA	Veterans' Health Administration
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	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 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. For more information, go to the PDC Overall Hospital Quality Star Ratings section. For more information regarding the Overall Hospital Quality Star Ratings methodology, go to the QualityNet.cms.gov Overall Hospital Quality Star Ratings Resources section.
Reporting Cycle	Data collection period will vary by measure and will be updated with each publication.

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 Refreshed annually.

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). 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 and presented on the Care Compare on Medicare.gov 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 Care Compare on Medicare.gov). The THA/TKA Complication Measure Methodology Report is available on QualityNet.cms.gov.
Reporting Cycle	Collection period: 36 months. Refreshed annually.

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. 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). 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).
Reporting Cycle	Collection period: 24 months. Refreshed annually.

Name	Complications: Healthcare-Associated Infections (HAI) Measures
Description/ Background	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), **c**atheter-associated urinary tract infections (CAUTI), surgical site infection (SSI) from colon surgery or abdominal hysterectomy, methicillin-resistant *Staphylococcus Aureus* (MRSA) blood laboratory-identified events (bloodstream infections), and *Clostridium difficile* (*C.diff*.) 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.
Reporting Cycle	Collection period: 12 months. Refreshed quarterly.

Name	Complications: 30-Day Mortality Measures
Description/ Background	The 30-day death measures are estimates of deaths within 30 days of the start 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); additionally, hospital wide mortality (HWM) is also reported. 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 and presented on the Care Compare on Medicare.gov website as percentages. Lower rates for mortality are better. Note that the rates for the heart attack (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), and coronary artery bypass graft (CABG) mortality measures included in the Hospital Value-Based Purchasing (HVBP) Program dataset are survival rates, not death rates. The Mortality Measures Methodology Reports are available on QualityNet.cms.gov.
Reporting Cycle	Collection period: 36 months for all measures. Refreshed annually.

Name	Comprehensive Care for Joint Replacement Model
Description/ Background	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: • 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 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).
Reporting Cycle	Collection period: CJR HCAHPS – 12 months, refreshed annually, CJR Hip/Knee Complications – 36 months. Refreshed annually. PRO data is refreshed annually.

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 (CABG) surgery 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.

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 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.

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	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 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). The HVBP measure dates are available the HVBP Overview page on QualityNet.cms.gov and Measures are available on QualityNet.cms.gov.
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	Maternal Health Measures
Description/ Background	These measures are intended to drive improvements in maternal health. By providing care to pregnant women that follows best practices that advance health care quality, safety, and equity, hospitals and doctors can improve chances for a safe delivery and a healthy baby.
Reporting Cycle	Collection period: 12 months. Refreshed annually.

Name	Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey
Description/ Background	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. 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).
Reporting Cycle	Collection period: 12 months. Refreshed quarterly.

Name	Patient Reported Outcomes
Description/ Background	Patient-Reported Outcomes Performance-Based Measures (PRO-PMs) capture patients' voices directly, measuring aspects of care that matter most to them, like pain management, functional ability, and overall quality of life. Through standardized surveys or questionnaires, patients report their pain and functional status, giving insights into their outcomes the effectiveness of the care they received by their provider.
Reporting Cycle	Collection period: 6 months: refreshed annually.

Name	Payment Measure
Description/ Background	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. The MSBP Measure Methodology Report is available on QualityNet.cms.gov.
Reporting Cycle	Collection Period: 12 months; refreshed annually

Name	Promoting Interoperability (PI)
Description/ Background	To continue a commitment to promoting and prioritizing interoperability and exchange of health care data, CMS renamed the EHR Incentive Programs to the Medicare and Medicaid Promoting Interoperability Programs in April 2018. This change moved the programs beyond the existing requirements of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving patient access to health information. Medicare Promoting Interoperability Program participants are required to report on all the program's objectives and measures or claim an applicable exclusion.
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 hysterectomy (PCH-07), methicillin-resistant *Staphylococcus Aureus* (MRSA) (PCH-27), and *Clostridium difficile* (*C.diff*.) laboratory-identified events (intestinal infections) PCH-26), Central Line-Associated Bloodstream Infection (CLABSI) (PCH-4), Catheter-Associated Urinary Tract Infections (CAUTI) (PCH-5). 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) and an unplanned readmission for cancer patients measure (PCH-36). PPS-Exempt Cancer Hospitals also submit Surgical treatment complications for localized prostate cancer (PCH-37). PPS-Exempt Cancer Hospitals also submit Palliative Care Measures including: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life (PCH-32), Proportion of patients who died from cancer admitted to the ICU in the in the last 30 days of life (PCH-33), Proportion of patients who died from cancer not admitted to hospice (PCH-34), and Proportion of patients who died from cancer admitted to hospice for less than 3 days (PCH-35).
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 and COVID-19 Vaccination coverage measures are refreshed quarterly.

Name	Rural Emergency Hospitals Timely and Effective Care
Description/ Background	The Rural Emergency Hospitals (REH) Quality Reporting Program seeks to gather and publicly report information on care provided by these hospitals so that such information is available to inform patient choice for choosing where to obtain care as well as toward improving quality and efficiency of care. This data set includes data for timely and effective care (process of care) quality measures included under the REH program.
Reporting Cycle	Collection period: 12 months: refreshed annually.

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, COVID-19 Vaccination, cataract care follow-up, colonoscopy follow-up, heart attack care, preventive care, cancer care measures, stroke, venous thromboembolism, hospital harm, and ST-Segment Elevation Myocardial Infarction.
Reporting Cycle	Collection period: 12 months. Refreshed annually: EDV-1, GMCS, OP-22, OP-29, OP-31, IMM-3, HH-HYPO, HH-HYPER, HH-ORAE, OP-40, Safe Use of Opioids, STK-02, STK-03, STK-05,VTE-01, and VTE-02 12 months. Refreshed quarterly: SEP-1, OP-18a, OP-18b, OP-18c, OP-18d and OP-23 6 months. Refreshed annually: IMM-3

Name	Unplanned hospital visits: By Condition
Description/ Background	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 is 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 (excess days in acute care or EDAC 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, HF, and pneumonia. The measures compare each hospital's return days to zero, which reflects the expectation that the hospital's "days" will be no different than an average performing hospital with a similar case mix. Readmission rates are provided in the downloadable databases and presented on the Care Compare on Medicare.gov website as percentages. Lower rates for readmission are better. Hospital return (EDAC) results are also provided in the downloadable databases but are presented in days per 100 discharges and can be negative, zero, or positive. A negative EDAC result is better and indicates that a hospital's patients spent fewer days in acute care than would be expected if admitted to an average performing hospital with the same case mix. A positive EDAC indicates a hospital's patients spent more days in acute care than would be expected, and an EDAC of zero indicates a hospital is performing exactly as expected. The Readmissions Measures Methodology Report is available on QualityNet.cms.gov. The EDAC Measure Methodology Report is available on QualityNet.cms.gov.
Reporting Cycle	Collection period: 36 months for all measures. Refreshed annually.

Name	Unplanned hospital visits: By Procedure
Description/ Background	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. The CABG surgery and hip/knee replacement readmission measures are estimates of unplanned readmission to any acute care hospital within 30 days after discharge from a 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 surgery, and hip/knee replacement measures are compared to the national rate to determine if hospitals' performance is better than the national rate (lower), no different than the national rate (the same), or worse than the national rate (higher). 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. The Readmissions Measure Methodology Report is available on QualityNet.cms.gov. The Colonoscopy, Chemotherapy, and Surgery Measure Methodology Reports are available on QualityNet.cms.gov.
Reporting Cycle	Collection period: 36 months for colonoscopy, CABG, and hip/knee replacement measures; 12 months for chemotherapy and surgery measures. Refreshed annually.

Name	Unplanned hospital visits: Overall
Description/ Background	The 30-day unplanned hospital-wide readmission measure is an estimate of unplanned readmission to any acute care hospital within 30 days of discharge from a hospitalization for any cause. The hospital-wide readmission measure includes all eligible medical, surgical and gynecological, neurological, cardiovascular, and cardiorespiratory admissions. Hospitals' rates 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 (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 and presented on the Care Compare website as percentages. Lower rates are better. The Hospital-Wide Readmission Measure Methodology Report is available on QualityNet.cms.gov.
Reporting Cycle	Collection period: 12 months. Refreshed annually.

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.

Measure Dates

The downloadable databases are refreshed within 24 hours of the Care Compare on Medicare.gov data update. The Measure Dates file located within the downloadable databases contains a comprehensive listing of all measures displayed on Care Compare on Medicare.gov, their start quarters and dates, and their end quarters and dates. A sample of the collection periods from the October 2025 Measure Dates file is shown below:

Measure ID	Measure Name	Measure Start Quarter	Start Date	Measure End Quarter	End Date
ASC_1	Number of patients who experience a burn prior to discharge from the ASC	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_11	Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_12	Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy	1Q2021	1/1/2021	4Q2023	12/31/2023
ASC_13	Percentage of patients who received anesthesia who had a body temperature of 96.8 Fahrenheit within 15 minutes of arriving in the post-anesthesia care unit	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_14	Percentage of cataract surgeries that had an unplanned additional eye surgery (anterior vitrectomy)	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_17	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures	1Q2022	1/1/2022	4Q2023	12/31/2023
ASC_18	Hospital Visits after Urology Ambulatory Surgical Center Procedures	1Q2022	1/1/2022	4Q2023	12/31/2023
ASC_19	Hospital Visits after General Surgery Procedures Performed	1Q2022	1/1/2022	4Q2023	12/31/2023
ASC_2	Number of patients who experience a fall within the ASC	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_3	Number of patients who experience a wrong site, side, patient, procedure, or implant	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_4	Percentage of ASC patients who are transferred or admitted to a hospital upon discharge from the ASC	1Q2024	1/1/2024	4Q2024	12/31/2024
ASC_9	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy	1Q2024	1/1/2024	4Q2024	12/31/2024
COMP_HIP_KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2Q2021	4/1/2021	1Q2024	3/31/2024
COMP_HIP_KNEE_HVBP_Baseline	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2Q2015	4/1/2015	1Q2018	3/31/2018
COMP_HIP_KNEE_HVBP_Performance	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	2Q2020	4/1/2020	1Q2023	3/31/2023
EDAC_30_AMI	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	3Q2021	7/1/2021	2Q2024	6/30/2024
EDAC_30_HF	Excess Days in Acute Care after Hospitalization for Heart Failure	3Q2021	7/1/2021	2Q2024	6/30/2024
EDAC_30_PN	Excess Days in Acute Care after Hospitalization for Pneumonia	3Q2021	7/1/2021	2Q2024	6/30/2024
EDV	Emergency Department Volume	1Q2023	1/1/2023	4Q2023	12/31/2023

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 January 2018 – July 2025.

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_Quality_Reporting_January_2025_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_October 2025.csv
Footnote_Crosswalk.csv
FY2021_Distribution_of_Net_Change_in_Base_Op_DRG_Payment_Amt.csv
FY2021_Net_Change_in_Base_Op_DRG_Payment_Amt.csv
FY2021_Percent_Change_in_Medicare_Payments.csv
FY2021_Value_Based_Incentive_Payment_Amount.csv
FY_2025_HAC_Reduction_Program_Hospital.csv
FY_2025_Hospital_Readmissions_Reduction_Program_Hospital.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

Hospital_General_Information.csv
HOSPITAL_QUARTERLY_MSPB_6_DECIMALS.csv
hvbp_clinical_outcomes.csv
hvbp_efficiency_and_cost_reduction.csv
hvbp_ person_and_community_engagement.csv
hvbp_safety.csv
hvbp_tps.csv
IPFQR_QualityMeasures_Facility.csv
IPFQR_QualityMeasures_National.csv
IPFQR_QualityMeasures_State.csv
Maternal_Health-Hospital.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
OQR_OAS_CAHPS_BY_HOSPITAL.csv
OQR_OAS_CAHPS_NATIONAL.csv
OQR_OAS_CAHPS_STATE.csv
Outpatient_Imaging_Efficiency-Hospital.csv
Outpatient_Imaging_Efficiency-National.csv
Outpatient_Imaging_Efficiency-State.csv
Patient_Reported_Outcomes_Facility.csv
PCH_Complications_Unplanned_Hospital_Visits_HOSPITAL.csv
PCH_Complications_Unplanned_Hospital_Visits_NATIONAL.csv
PCH_Palliative_Care_HOSPITAL.csv
PCH_Palliative_Care_NATIONAL.csv
PCH_HEALTHCARE_ASSOCIATED_INFECTIONS_HOSPITAL.csv
PCH_HCAHPS_HOSPITAL.csv

PCH_HCAHPS_NATIONAL.csv
PCH_HCAHPS_STATE.csv
Promoting_Interoperability-Hospital.csv
REH Timely and Effective Care-Hospital.csv
REH Timely and Effective Care-National.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
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 2018 - 2024 are available in the Data Archive page found in the Hospital Topics section of the Provider Data Catalog site.

General Information

Table	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(74)	Facility Name
Char(51)	Address
Char(24)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(36)	Hospital Type
Char(43)	Hospital Ownership
Char(3)	Emergency Services
Char(1)	Meets criteria for birthing friendly designation
Char(13)	Hospital overall rating
Char(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
Num(8)	MORT Group Footnote
Char(13)	Safety Group Measure Count

Table	Hospital General Information
Description	General information on hospitals within the dataset
File Name	HOSPITAL_GENERAL_INFORMATION.CSV
Data Type	**Column Name - CSV**
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	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_OCTOBER_2025.CSV
Data Type	**Column Name - CSV**
Char(70)	https://data.cms.gov/provider-data/ location affected
Char(155)	Downloadable CSV revised file affected
Num(8)	Data Last Updated
Char(269)	Data Last Updated Details

Table	Footnote Crosswalk
Description	Look up table for footnote summary text
File Name	FOOTNOTE_CROSSWALK.CSV
Data Type	**Column Name - CSV**
Char(2)	Footnote
Char(225)	Footnote Text

Table	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(155)	Measure Name
Char(6)	Measure Start Quarter
Date	Start Date
Char(6)	Measure End Quarter
Date	End Date

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Table	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(107)	Facility Name
Char(10)	Facility ID
Num(8)	NPI
Char(21)	City/Town
Char(2)	State
Num(8)	ZIP Code
Num(8)	Year
Char(5)	ASC-1 Rate*

Table	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**
Num(8)	ASC-1 Footnote
Char(5)	ASC-2 Rate*
Num(8)	ASC-2 Footnote
Char(5)	ASC-3 Rate*
Num(8)	ASC-3 Footnote
Char(5)	ASC-4 Rate*
Num(8)	ASC-4 Footnote
Char(6)	ASC-9 Rate*
Num(8)	ASC-9 Footnote
Char(6)	ASC-11 Rate*
Num(8)	ASC-11 Footnote
Char(5)	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(6)	ASC-13 Rate*
Num(8)	ASC-13 Footnote
Char(7)	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
Char(3)	ASC-17 Interval Upper Limit
Num(8)	ASC-17 Footnote
Char(4)	ASC-18 Total Cases

Table	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(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
Char(4)	ASC-19 Total Cases
Char(26)	ASC-19 Performance Category
Char(3)	ASC-19 RSHV Rate
Char(3)	ASC-19 Interval Lower Limit
Char(3)	ASC-19 Interval Upper Limit
Num(8)	ASC-19 Footnote

Table	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-1 Nat Rate*
Num(8)	Median ASC-1 Nat Rate*
Num(8)	Avg ASC-2 Nat Rate*
Num(8)	Median ASC-2 Nat Rate*
Num(8)	Avg ASC-3 Nat Rate*
Num(8)	Median ASC-3 Nat Rate*
Num(8)	Avg ASC-4 Nat Rate*
Num(8)	Median ASC-4 Nat Rate*
Num(8)	Avg ASC-9 Nat Rate*
Num(8)	Median ASC-9 Nat Rate*

Table	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)	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*
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
Num(8)	ASC-19 Nat Rate
Num(8)	ASC-19 Better
Num(8)	ASC-19 No Different
Num(8)	ASC-19 Worse
Num(8)	ASC-19 Too Small

Table	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-1 State Rate*
Char(7)	Median ASC-1 State Rate*
Num(8)	Avg ASC-2 State Rate*
Num(8)	Median ASC-2 State Rate*
Char(7)	Avg ASC-3 State Rate*
Char(7)	Median ASC-3 State Rate*
Num(8)	Avg ASC-4 State Rate*
Num(8)	Median ASC-4 State Rate*
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
Num(8)	ASC-12 No Different
Num(8)	ASC-12 Worse
Num(8)	ASC-12 Too Small
Num(8)	Avg ASC-13 State Rate*
Num(8)	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

Table	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-18 Worse
Num(8)	ASC-18 Too Small
Num(8)	ASC-19 Better
Num(8)	ASC-19 No Different
Num(8)	ASC-19 Worse
Num(8)	ASC-19 Too Small

Complications and Deaths

Table	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
Char(39)	Address
Char(19)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone 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

Table	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(7)	Footnote
Date	Start Date
Date	End Date

Table	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
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	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

Table	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(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	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(43)	Address
Char(19)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(6)	Measure ID
Char(64)	Measure Name
Char(13)	Rate
Num(8)	Footnote
Date	Start Date
Date	End Date

Comprehensive Care for Joint Replacement (CJR) Model

Table	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_QUALITY_REPORTING_JANUARY_2025_PRODUCTION_FILE.CSV
Data Type	**Column Name - CSV**
Num(8)	Facility ID
Char(57)	Facility Name
Num(8)	MSA
Char(43)	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

Survey of Patients' Experiences

Table	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(74)	Facility Name
Char(43)	Address
Char(19)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone 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(8)	HCAHPS Answer Percent Footnote
Char(14)	HCAHPS Linear Mean Value
Char(13)	Number of Completed Surveys
Char(8)	Number of Completed Surveys Footnote
Char(13)	Survey Response Rate Percent
Char(8)	Survey Response Rate Percent Footnote
Date	Start Date
Date	End Date

Table	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(25)	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	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(25)	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

Outpatient and Ambulatory Surgical Center (OAS) CAHPS

Outpatient CAHPS

Table	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
Char(72)	Facility Name
Char(39)	Address
Char(19)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(27)	OAS CAHPS Measure ID
Char(112)	OAS CAHPS Question
Char(90)	OAS CAHPS Answer Description
Char(14)	OAS CAHPS Answer Percent
Char(7)	OAS CAHPS Answer Percent Footnote
Char(14)	OAS CAHPS 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	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**
Char(21)	OAS CAHPS Measure ID
Char(112)	OAS CAHPS Question
Char(90)	OAS CAHPS Answer Description
Num(8)	OAS CAHPS Answer Percent
Char(1)	OAS CAHPS Answer Percent Footnote
Date	Start Date
Date	End Date

Table	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(2)	State
Char(21)	OAS CAHPS Measure ID
Char(112)	OAS CAHPS Question
Char(90)	OAS CAHPS Answer Description
Char(13)	OAS CAHPS Answer Percent
Num(8)	OAS CAHPS Answer Percent Footnote
Date	Start Date
Date	End Date

Ambulatory Surgical Center CAHPS

Table	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(90)	Facility Name
Char(49)	Address
Char(21)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(1)	County/Parish
Char(14)	Telephone Number
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	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)	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(6)	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	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

Table	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 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	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)
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	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)	Survey Response Rate Percent
Date	Start Date
Date	End Date

Healthcare-associated Infections (HAI)

Table	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(15)	Measure ID
Char(98)	Measure Name
Char(36)	Compared to National
Char(13)	Score
Char(11)	Footnote
Date	Start Date
Date	End Date

Table	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
Char(66)	Measure Name
Num(8)	Score
Char(1)	Footnote
Date	Start Date
Date	End Date

Table	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

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Table	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
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(39)	SMD Measure Description
Char(13)	SMD %
Char(13)	SMD Denominator
Num(8)	SMD Footnote
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 %

Table	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(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(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
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
Date	Start Date
Date	End Date
Char(129)	FAPH Measure Description
Char(13)	FAPH-30 %
Char(13)	FAPH-30 Denominator
Num(8)	FAPH-30 Footnote
Char(13)	FAPH-7 %
Char(13)	FAPH-7 Denominator

Table	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)	FAPH-7 Footnote
Date	FAPH Measure Start Date
Date	FAPH Measure End Date
Char(65)	MedCont Measure Desc
Char(13)	MedCont %
Char(13)	MedCont Denominator
Char(7)	MedCont Footnote
Date	MedCont Measure Start Date
Date	MedCont Measure End Date
Char(118)	READM-30-IPF Measure Desc
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	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
Num(8)	N HBIPS-3 Overall Num
Num(8)	N HBIPS-3 Overall Den
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(54)	TOB-3/-3a Measure Description
Num(8)	N TOB-3 %
Num(8)	TOB-3 Top 10%
Num(8)	N TOB-3a %
Num(8)	TOB-3a Top 10%
Char(79)	TR-1 Measure Description
Num(8)	N TR-1 %

Table	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)	TR-1 Top 10%
Date	Start Date
Date	End Date
Char(129)	FAPH Measure Description
Num(8)	N FAPH-30 %
Num(8)	FAPH-30 Top 10%
Num(8)	N FAPH-7 %
Num(8)	FAPH-7 Top 10%
Date	FAPH Measure Start Date
Date	FAPH 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
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	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(39)	SMD Measure Description
Num(8)	S SMD %
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(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 %
Date	Start Date
Date	End Date
Char(129)	FAPH Measure Description
Char(13)	S FAPH-30 %
Char(13)	S FAPH-7 %

Table	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**
Date	FAPH Measure Start Date
Date	FAPH Measure End Date
Char(65)	MedCont Measure Description
Char(13)	S MedCont %
Date	MedCont Measure Start Date
Date	MedCont Measure End Date
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

Linking Quality to Payment

Hospital-Acquired Conditions Reduction Program (HACRP)

Table	HACRP
Description	Hospital-level results for Hospital-Acquired Condition Reduction Program measures
File Name	FY_2025_HAC_REDUCTION_PROGRAM_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(216)	Facility Name

Table	HACRP
Description	Hospital-level results for Hospital-Acquired Condition Reduction Program measures
File Name	FY_2025_HAC_REDUCTION_PROGRAM_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Num(8)	Facility ID
Char(2)	State
Num(8)	Fiscal Year
Char(6)	PSI 90 Composite Value
Char(7)	PSI 90 Composite Value Footnote
Char(7)	PSI 90 W Z Score
Num(8)	PSI 90 W Z Footnote
Date	PSI 90 Start Date
Date	PSI 90 End Date
Char(5)	CLABSI SIR
Num(8)	CLABSI SIR Footnote
Char(7)	CLABSI W Z Score
Num(8)	CLABSI W Z Footnote
Char(5)	CAUTI SIR
Num(8)	CAUTI SIR Footnote
Char(7)	CAUTI W Z Score
Num(8)	CAUTI W Z Footnote
Char(5)	SSI SIR
Num(8)	SSI SIR Footnote
Char(7)	SSI W Z Score
Num(8)	SSI W Z Footnote
Char(5)	CDI SIR
Num(8)	CDI SIR Footnote
Char(7)	CDI W Z Score
Num(8)	CDI W Z Footnote
Char(5)	MRSA SIR
Num(8)	MRSA SIR Footnote

Table	HACRP
Description	Hospital-level results for Hospital-Acquired Condition Reduction Program measures
File Name	FY_2025_HAC_REDUCTION_PROGRAM_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(7)	MRSA W Z Score
Num(8)	MRSA W Z Footnote
Date	HAI Measures Start Date
Date	HAI Measures End Date
Char(7)	Total HAC Score
Num(8)	Total HAC Score Footnote
Char(3)	Payment Reduction
Char(1)	Payment Reduction Footnote

Hospital Readmission Reduction Program (HRRP)

Table	HRRP
Description	Hospital-level results for Hospital Readmissions Reduction Program measures
File Name	FY_2025_HOSPITAL_READMISSIONS_REDUCTION_PROGRAM_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(147)	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

Table	HRRP
Description	Hospital-level results for Hospital Readmissions Reduction Program measures
File Name	FY_2025_HOSPITAL_READMISSIONS_REDUCTION_PROGRAM_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Date	Start Date
Date	End Date

Hospital Value-Based Purchasing (HVBP) Program

Table	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**
Num(8)	Fiscal Year
Num(8)	Facility ID
Char(71)	Facility Name
Char(50)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
Num(8)	MORT-30-AMI Achievement Threshold
Num(8)	MORT-30-AMI Benchmark
Char(13)	MORT-30-AMI Baseline Rate
Char(13)	MORT-30-AMI Performance Rate
Char(13)	MORT-30-AMI Achievement Points
Char(13)	MORT-30-AMI Improvement Points
Char(13)	MORT-30-AMI Measure Score
Num(8)	MORT-30-HF Achievement Threshold
Num(8)	MORT-30-HF Benchmark
Char(13)	MORT-30-HF Baseline Rate

Table	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(13)	MORT-30-HF Performance Rate
Char(13)	MORT-30-HF Achievement Points
Char(13)	MORT-30-HF Improvement Points
Char(13)	MORT-30-HF Measure Score
Num(8)	MORT-30-PN Achievement Threshold
Num(8)	MORT-30-PN Benchmark
Char(13)	MORT-30-PN Baseline Rate
Char(13)	MORT-30-PN Performance Rate
Char(13)	MORT-30-PN Achievement Points
Char(13)	MORT-30-PN Improvement Points
Char(13)	MORT-30-PN Measure Score
Num(8)	MORT-30-COPD Achievement Threshold
Num(8)	MORT-30-COPD Benchmark
Char(13)	MORT-30-COPD Baseline Rate
Char(13)	MORT-30-COPD Performance Rate
Char(13)	MORT-30-COPD Achievement Points
Char(13)	MORT-30-COPD Improvement Points
Char(13)	MORT-30-COPD Measure Score
Num(8)	MORT-30-CABG Achievement Threshold
Num(8)	MORT-30-CABG Benchmark
Char(13)	MORT-30-CABG Baseline Rate
Char(13)	MORT-30-CABG Performance Rate
Char(13)	MORT-30-CABG Achievement Points
Char(13)	MORT-30-CABG Improvement Points
Char(13)	MORT-30-CABG Measure Score
Num(8)	COMP-HIP-KNEE Achievement Threshold
Num(8)	COMP-HIP-KNEE Benchmark
Char(13)	COMP-HIP-KNEE Baseline Rate

Table	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(13)	COMP-HIP-KNEE Performance Rate
Char(13)	COMP-HIP-KNEE Achievement Points
Char(13)	COMP-HIP-KNEE Improvement Points
Char(13)	COMP-HIP-KNEE Measure Score

Table	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**
Num(8)	Fiscal Year
Num(8)	Facility ID
Char(71)	Facility Name
Char(50)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
Char(6)	Communication With Nurses Floor
Char(6)	Communication With Nurses Achievement Threshold
Char(6)	Communication With Nurses Benchmark
Char(13)	Communication With Nurses Baseline Rate
Char(13)	Communication With Nurses Performance Rate
Char(13)	Communication With Nurses Achievement Points
Char(13)	Communication With Nurses Improvement Points
Char(13)	Communication With Nurses Dimension Score
Char(6)	Communication With Doctors Floor

Table	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)	Communication With Doctors Achievement Threshold
Char(6)	Communication With Doctors Benchmark
Char(13)	Communication With Doctors Baseline Rate
Char(13)	Communication With Doctors Performance Rate
Char(13)	Communication With Doctors Achievement Points
Char(13)	Communication With Doctors Improvement Points
Char(13)	Communication With Doctors Dimension Score
Char(6)	Responsiveness Of Hospital Staff Floor
Char(6)	Responsiveness Of Hospital Staff Achievement Threshold
Char(6)	Responsiveness Of Hospital Staff Benchmark
Char(13)	Responsiveness Of Hospital Staff Baseline Rate
Char(13)	Responsiveness Of Hospital Staff Performance Rate
Char(13)	Responsiveness Of Hospital Staff Achievement Points
Char(13)	Responsiveness Of Hospital Staff Improvement Points
Char(13)	Responsiveness Of Hospital Staff Dimension Score
Char(6)	Care Transition Floor
Char(6)	Care Transition Achievement Threshold
Char(6)	Care Transition Benchmark
Char(13)	Care Transition Baseline Rate
Char(13)	Care Transition Performance Rate
Char(13)	Care Transition Achievement Points
Char(13)	Care Transition Improvement Points
Char(13)	Care Transition Dimension Score
Char(6)	Communication About Medicines Floor
Char(6)	Communication About Medicines Achievement Threshold
Char(6)	Communication About Medicines Benchmark

Table	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)	Communication About Medicines Baseline Rate
Char(13)	Communication About Medicines Performance Rate
Char(13)	Communication About Medicines Achievement Points
Char(13)	Communication About Medicines Improvement Points
Char(13)	Communication About Medicines Dimension Score
Char(6)	Cleanliness And Quietness Of Hospital Environment Floor
Char(6)	Cleanliness And Quietness Of Hospital Environment Achievement Threshold
Char(6)	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(13)	Cleanliness And Quietness Of Hospital Environment Achievement Points
Char(13)	Cleanliness And Quietness Of Hospital Environment Improvement Points
Char(13)	Cleanliness And Quietness Of Hospital Environment Dimension Score
Char(6)	Discharge Information Floor
Char(6)	Discharge Information Achievement Threshold
Char(6)	Discharge Information Benchmark
Char(13)	Discharge Information Baseline Rate
Char(13)	Discharge Information Performance Rate
Char(13)	Discharge Information Achievement Points
Char(13)	Discharge Information Improvement Points
Char(13)	Discharge Information Dimension Score

Table	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)	Overall Rating Of Hospital Floor
Char(6)	Overall Rating Of Hospital Achievement Threshold
Char(6)	Overall Rating Of Hospital Benchmark
Char(13)	Overall Rating Of Hospital Baseline Rate
Char(13)	Overall Rating Of Hospital Performance Rate
Char(13)	Overall Rating Of Hospital Achievement Points
Char(13)	Overall Rating Of Hospital Improvement Points
Char(13)	Overall Rating Of Hospital Dimension Score
Char(13)	Hcahps Base Score
Char(13)	Hcahps Consistency Score

Table	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**
Num(8)	Fiscal Year
Num(8)	Facility ID
Char(71)	Facility Name
Char(50)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
Num(8)	MSPB-1 Achievement Threshold
Num(8)	MSPB-1 Benchmark
Char(13)	MSPB-1 Baseline Rate

Table	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**
Num(8)	MSPB-1 Performance Rate
Char(12)	MSPB-1 Achievement Points
Char(13)	MSPB-1 Improvement Points
Char(12)	MSPB-1 Measure Score

Table	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**
Num(8)	Fiscal Year
Num(8)	Facility ID
Char(71)	Facility Name
Char(50)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
Num(8)	HAI-1 Achievement Threshold
Num(8)	HAI-1 Benchmark
Char(13)	HAI-1 Baseline Rate
Char(13)	HAI-1 Performance Rate
Char(13)	HAI-1 Achievement Points
Char(13)	HAI-1 Improvement Points
Char(13)	HAI-1 Measure Score
Num(8)	HAI-2 Achievement Threshold
Num(8)	HAI-2 Benchmark

Table	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-2 Baseline Rate
Char(13)	HAI-2 Performance Rate
Char(13)	HAI-2 Achievement Points
Char(13)	HAI-2 Improvement Points
Char(13)	HAI-2 Measure Score
Char(13)	Combined SSI Measure Score
Num(8)	HAI-3 Achievement Threshold
Num(8)	HAI-3 Benchmark
Char(13)	HAI-3 Baseline Rate
Char(13)	HAI-3 Performance Rate
Char(13)	HAI-3 Achievement Points
Char(13)	HAI-3 Improvement Points
Char(13)	HAI-3 Measure Score
Num(8)	HAI-4 Achievement Threshold
Num(8)	HAI-4 Benchmark
Char(13)	HAI-4 Baseline Rate
Char(13)	HAI-4 Performance Rate
Char(13)	HAI-4 Achievement Points
Char(13)	HAI-4 Improvement Points
Char(13)	HAI-4 Measure Score
Num(8)	HAI-5 Achievement Threshold
Num(8)	HAI-5 Benchmark
Char(13)	HAI-5 Baseline Rate
Char(13)	HAI-5 Performance Rate
Char(13)	HAI-5 Achievement Points
Char(13)	HAI-5 Improvement Points
Char(13)	HAI-5 Measure Score

Table	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**
Num(8)	HAI-6 Achievement Threshold
Num(8)	HAI-6 Benchmark
Char(13)	HAI-6 Baseline Rate
Char(13)	HAI-6 Performance Rate
Char(13)	HAI-6 Achievement Points
Char(13)	HAI-6 Improvement Points
Char(13)	HAI-6 Measure Score

Table	HVBP - TPS
Description	Hospital-level total performance score for Hospital Value-Based Purchasing
File Name	HVBP_TPS.CSV
Data Type	**Column Name - CSV**
Num(8)	Fiscal Year
Num(8)	Facility ID
Char(71)	Facility Name
Char(50)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(20)	County/Parish
Char(15)	Unweighted Normalized Clinical Outcomes Domain Score
Char(15)	Weighted Normalized Clinical Outcomes Domain Score
Char(16)	Unweighted Person And Community Engagement Domain Score
Char(15)	Weighted Person And Community Engagement Domain Score

Table	HVBP - TPS
Description	Hospital-level total performance score for Hospital Value-Based Purchasing
File Name	HVBP_TPS.CSV
Data Type	**Column Name - CSV**
Char(16)	Unweighted Normalized Safety Domain Score
Char(15)	Weighted Safety Domain Score
Num(8)	Unweighted Normalized Efficiency And Cost Reduction Domain Score
Num(8)	Weighted Efficiency And Cost Reduction Domain Score
Num(8)	Total Performance Score

HVBP Program Incentive Payment Adjustments

Table	HVBP FY 2021 Distribution of Net Change
Description	Distribution of net change in base operating diagnosis-related group payment amount
File Name	FY2021_DISTRIBUTION_OF_NET_CHANGE_IN_BASE_OP_DRG_PAYMENT_AMT.CSV
Data Type	**Column Name - CSV**
Char(4)	Percentile
Char(12)	Net Change in Base Operating DRG Payment Amount

Table	HVBP FY 2021 Net Change
Description	Net change in base operating diagnosis-related group payment amount
File Name	FY2021_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	HVBP FY 2021 Percent Change
Description	Percent change in base operating diagnosis-related group payment amount
File Name	FY2021_PERCENT_CHANGE_IN_MEDICARE_PAYMENTS.CSV
Data Type	**Column Name - CSV**
Char(16)	% Change in Base Operating DRG Payment Amount
Num(8)	Number of Hospitals Receiving this % Change

Table	HVBP FY 2021 Incentive Payment
Description	Value-based incentive payment amount
File Name	FY2021_VALUE_BASED_INCENTIVE_PAYMENT_AMOUNT.CSV
Data Type	**Column Name - CSV**
Char(83)	Incentive Payment Range
Num(8)	Number of Hospitals Receiving this Range

Maternal Health

Table	Maternal Health (Hospital)
Description	Hospital-level results for maternal health measures
File Name	MATERNAL_HEALTH-HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(6)	Facility ID
Char(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(6)	Measure ID
Char(85)	Measure Name

Table	Maternal Health (Hospital)
Description	Hospital-level results for maternal health measures
File Name	MATERNAL_HEALTH-HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(76)	Score
Char(14)	Sample
Num(8)	Footnote
Date	Start Date
Date	End Date

Medicare Spending per Beneficiary (MSPB)

Table	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(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(6)	Measure ID
Char(74)	Measure Name
Char(13)	Score
Num(8)	Footnote
Date	Start Date
Date	End Date

Table	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	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
Num(8)	Footnote
Date	Start Date
Date	End Date

Table	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	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(196)	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

Patient Reported Outcomes

Table	Patient Reported Outcomes (Facility)
Description	Hospital-level results for Pre-operative assessment response rate for hip/knee replacement patients
File Name	PATIENT_REPORTED_OUTCOMES_FACILITY.CSV
Data Type	**Column Name - CSV**
Num(8)	Facility ID
Char(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(14)	Measure ID
Char(112)	Measure Name
Char(3)	Voluntary_Reporting
Char(13)	Score
Num(8)	Footnote
Date	Start Date
Date	End Date

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Table	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

Table	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**
Char(24)	Address
Char(12)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(12)	County/Parish
Char(17)	Measure ID
Char(96)	Measure Name
Char(13)	Score
Num(8)	Footnote
Date	Start Date
Date	End Date

Table	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(12)	County/Parish
Char(14)	Telephone Number
Char(25)	HCAHPS Measure ID
Char(138)	HCAHPS Question

Table	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(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
Num(8)	Number of Completed Surveys
Num(8)	Number of Completed Surveys Footnote
Num(8)	Survey Response Rate Percent
Num(8)	Survey Response Rate Percent Footnote
Date	Start Date
Date	End Date

Table	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	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
Char(138)	HCAHPS Question
Char(118)	HCAHPS Answer Description
Char(13)	HCAHPS Answer Percent
Date	Start Date
Date	End Date

Table	PCHQR-Complications and Unplanned Hospital Visits (Hospital)
Description	Hospital-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure
File Name	PCH_COMPLICATIONS_UNPLANNED_HOSPITAL_VISITS_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/Town
Char(2)	State
Num(8)	ZIP Code
Char(12)	County/Parish
Char(6)	Measure ID
Char(79)	Measure Description
Char(13)	Total Cases
Char(35)	Performance Category
Char(13)	Rate

Table	PCHQR-Complications and Unplanned Hospital Visits (Hospital)
Description	Hospital-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure
File Name	PCH_COMPLICATIONS_UNPLANNED_HOSPITAL_VISITS_HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(14)	Interval Lower Limit
Char(14)	Interval Upper Limit
Num(8)	Footnote
Date	Start Date
Date	End Date

Table	PCHQR-Complications and Unplanned Hospital Visits (National)
Description	National-level results for the PPS-Exempt Cancer Hospital Quality Reporting outcome measure
File Name	PCH_COMPLICATIONS_UNPLANNED_HOSPITAL_VISITS_NATIONAL.CSV
Data Type	**Column Name - CSV**
Char(6)	Measure ID
Char(79)	Measure Description
Num(8)	National Rate
Char(14)	Better
Char(14)	No Different
Char(14)	Worse
Char(14)	Too Small
Date	Start Date
Date	End Date

Table	PCH-Palliative Care (Hospital)
Description	Hospital-level results for the PPS-Exempt Cancer Hospital Quality Reporting Palliative Care measures
File Name	PCH_PALLIATIVE_CARE_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/Town
Char(2)	State
Num(8)	ZIP Code
Char(12)	County/Parish
Char(6)	Measure ID
Char(94)	Measure Description
Num(8)	Total Cases
Num(8)	Rate
Char(1)	Footnote
Date	Start Date
Date	End Date

Table	PCH-Palliative Care (National)
Description	National-level results for the PPS-Exempt Cancer Hospital Quality Reporting Palliative Care measures
File Name	PCH_PALLIATIVE_CARE_NATIONAL.CSV
Data Type	**Column Name - CSV**
Char(6)	Measure ID
Char(94)	Measure Description
Num(8)	National Rate
Date	Start Date
Date	End Date

Promoting Interoperability

Table	Promoting Interoperability (Hospital)
Description	Hospital-level results on Medicare's Promoting Interoperability program.
File Name	PROMOTING_INTEROPERABILITY-HOSPITAL.CSV
Data Type	**Column Name - CSV**
Num(8)	Facility ID
Char(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(15)	CEHRT ID
Char(1)	Meets criteria for promoting interoperability of EHRs
Date	Start Date
Date	End Date

Rural Emergency Hospitals Timely and Effective Care

Table	REH Timely and Effective Care (Hospital)
Description	Hospital-level results for Rural Emergency Hospitals' Process of Care measures
File Name	REH_TIMELY_AND_EFFECTIVE_CARE-HOSPITAL.CSV
Data Type	**Column Name - CSV**
Num(8)	Facility ID
Char(48)	Facility Name
Char(32)	Address
Char(14)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(13)	County/Parish

Table	REH Timely and Effective Care (Hospital)
Description	Hospital-level results for Rural Emergency Hospitals' Process of Care measures
File Name	REH_TIMELY_AND_EFFECTIVE_CARE-HOSPITAL.CSV
Data Type	**Column Name - CSV**
Char(14)	Telephone Number
Char(20)	Condition
Char(10)	Measure ID
Char(237)	Measure Name
Char(13)	Score
Char(13)	Sample
Char(6)	Footnote
Date	Start Date
Date	End Date

Table	REH Timely and Effective Care (National)
Description	National-level results for Rural Emergency Hospitals' Process of Care measures
File Name	REH_TIMELY_AND_EFFECTIVE_CARE-NATIONAL.CSV
Data Type	**Column Name - CSV**
Char(20)	Measure ID
Char(237)	Measure Name
Char(20)	Condition
Char(202)	Category
Num(8)	Score
Char(1)	Footnote
Date	Start Date
Date	End Date

Timely and Effective Care

Table	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
Char(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(35)	Condition
Char(38)	Measure ID
Char(237)	Measure Name
Char(13)	Score
Char(13)	Sample
Char(13)	Footnote
Date	Start Date
Date	End Date

Table	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(29)	Measure ID
Char(249)	Measure Name
Char(35)	Condition
Char(131)	Category
Num(8)	Score
Char(8)	Footnote

Table	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	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(35)	Condition
Char(20)	Measure ID
Char(249)	Measure Name
Char(13)	Score
Char(8)	Footnote
Date	Start Date
Date	End Date

Unplanned Hospital Visits

Table	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(43)	Address
Char(19)	City/Town
Char(2)	State
Num(8)	ZIP Code

Table	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(25)	County/Parish
Char(14)	Telephone Number
Char(17)	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	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(17)	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

Table	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**
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	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(17)	Measure ID
Char(87)	Measure Name
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
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	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(74)	Facility Name
Char(51)	Address
Char(20)	City/Town
Char(2)	State
Num(8)	ZIP Code
Char(25)	County/Parish
Char(14)	Telephone Number
Char(5)	Measure ID
Char(83)	Measure Name
Char(13)	Score
Char(7)	Footnote
Date	Start Date
Date	End Date

Table	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	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
Num(8)	Footnote
Date	Start Date
Date	End Date

Veterans' Health Administration Hospital Data

Table	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(15)	County/Parish
Char(14)	Telephone 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	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(15)	County/Parish
Char(14)	Telephone Number
Char(39)	Condition
Char(7)	Measure ID
Char(78)	Measure Name
Char(13)	Score
Char(13)	Sample
Char(7)	Footnote
Date	Start Date
Date	End Date

Table	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/Town
Char(2)	State
Num(8)	ZIP Code
Char(15)	County/Parish
Char(14)	Telephone Number
Char(35)	Condition
Char(6)	Measure ID
Char(108)	Measure Name
Char(10)	STTag
Char(13)	Score
Char(13)	Sample
Char(7)	Footnote
Date	Start Date
Date	End Date

Appendix A – Hospital Quality Initiatives Public Reporting 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 birthing friendly designation	This hospital meets criteria for being designated as a birthing friendly hospital.
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

ASC_Facility .csv

Measure ID	Measure Name
ASC-1	Number of patients who experience a burn prior to discharge from the ASC
ASC-2	Number of patients who experience a fall within the ASC
ASC-3	Number of patients who experience a wrong site, side, patient, procedure, or implant
ASC-4	Percentage of ASC patients who are transferred or admitted to a hospital upon discharge from the ASC
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
ASC-19	Hospital Visits after General Surgery Procedures Performed

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	In-hospital fall-associated fracture rate
PSI 09	Postoperative hemorrhage or hematoma rate (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
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
Hybrid HWM	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate

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	In-hospital fall-associated fracture rate
PSI 09	Postoperative hemorrhage or hematoma rate (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)

CJR_Quality_Reporting_January_2025_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

FY_2025 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_2025 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 ration 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

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
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-	Staff responsiveness - star rating

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

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 *Staphylococcus aureus* (or MRSA) blood laboratory-identified events (bloodstream infections) (alternate Measure ID: HAI_5_SIR)
HAI-6	*Clostridium difficile* (C.diff.) laboratory identified events (intestinal infections) (alternate Measure ID: HAI_6_SIR)

HVBP Measures Directory

File Name	Measure
hvbp_clinical_outcomes	MORT-30-AMI; MORT-30-HF; MORT-30-PN; MORT-30-COPD
hvbp_efficiency_and_cost_reduction	MSPB-1
hvbp_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
hvbp_safety	HAI-1; HAI-2; HAI-3; HAI-4, HAI-5, HAI-6
hvbp_tps	TPS Scores (Weighted and Unweighted) for Clinical Process of Care, Patient Experience of Care, Outcome, and Efficiency Domains

IPFQR_QualityMeasures_Facility.csv

Measure ID	Measure Name
FAPH-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.
FAPH-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
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-3	Tobacco use treatment provided or offered at discharge
TOB-3a	Tobacco use treatment at discharge
TR1	Transition Record with Specified Elements

Maternal_Health-Hospital.csv

Measure ID	Measure Name
PC-02	The rate of nulliparous women with a term, singleton baby in a vertex position delivered by C-section birth
PC-07a	Rate of any serious complications for mothers during delivery (per 10,000 deliveries)
PC-07b	Rate of serious complications (excluding blood transfusions) for mothers during delivery (per 10,000 deliveries)
SM-7	Assesses whether or not a hospital participates in a Statewide or National Perinatal Quality Improvement (QI) Collaborative Initiative

Medicare_Hospital_Spending_per_Patient–Hospital.csv

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

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
OP-39	Breast Cancer Screening Recall Rates

Patient_Reported_Outcomes_Facility.csv

Measure ID	Measure Name
THA/TKA PRO-PM	Pre-operative assessment response rate for hip/knee replacement patients

PCH_Complications_Unplanned_Hospital_Visits_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-36	30-Day Unplanned Readmission for Cancer Patients
PCH-37	Surgical Treatment Complications for Localized Prostate Cancer

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-4	Central Line-Associated Bloodstream Infection (CLABSI)
PCH-5	Catheter-Associated Urinary Tract Infections (CAUTI)
PCH-38	Percentage of healthcare personnel who are up to date with COVID-19 vaccinations
PCH-27	MRSA Bacteremia
PCH-26	*Clostridium Difficile* (C.Diff)
PCH-28	Influenza Vaccination Coverage Among Healthcare Personnel (HCP)

PCH_Palliative_Care_HOSPITAL.csv

Measure ID	Measure Name
PCH-32	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
PCH-33	Proportion of patients who died from cancer admitted to the ICU in the in the last 30 days of life
PCH-34	Proportion of patients who died from cancer not admitted to hospice
PCH-35	Proportion of patients who died from cancer admitted to hospice for less than 3 days

Promoting_Interoperability-Hospital.csv

Data Element	Description
CEHRT ID	Facility's Certified Electronic Health Record Technology identifier
Meets criteria for promoting interoperability of EHRs	Indicator for whether the hospital meets the criteria for the Medicare Promoting Interoperability Program

REH_Timely_and_Effective_Care-Hospital.csv

Measure ID	Measure Name
REH-OP-18a	Average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility.
REH-OP-18b	Average (median) time patients spent in the emergency department before leaving from the visit, excluding patients transferred to another facility or psychiatric care/mental health patients.
REH-OP-18c	Average (median) time psychiatric/mental health patients spent in the emergency department before leaving from the visit.
REH-OP-18d	Average (median) time patients spent in the emergency department before being transferred to another facility

Timely_and_Effective_Care–Hospital.csv

Measure ID	Measure Name
EDV	Emergency department volume (alternate Measure ID: EDV-1)
GMCS	Global Malnutrition Composite Score
GMCS: Malnutrition Screening	Percentage of patients admitted to an inpatient hospital who have malnutrition screening documented in the medical record
GMCS: Malnutrition Diagnosis Documented	Percentage of patients admitted to an inpatient hospital with findings of malnutrition, upon completing a nutrition assessment, who have a diagnosis of malnutrition documented in the medical record
GMCS: Nutrition Assessment	Percentage of patients admitted to an inpatient hospital and were identified as at-risk for malnutrition upon completing a malnutrition screening who have a nutrition assessment document in the medical record
GMCS: Nutrition Care Plan	Percentage of patients admitted to an inpatient hospital with finding of malnutrition, upon completing a nutrition assessment, who have a nutrition care plan documented in the medical record
HH-HYPO	Proportion of patients who had a low blood glucose test result (less than 40 mg/dL) and no subsequent confirmatory blood glucose within 5 minutes and in the normal range (greater than 80 mg/dL)

Measure ID	Measure Name
HH-HYPER	Number of hospital days for patients with a hyperglycemic event among the total qualifying hospital days for at risk inpatient encounters
HH-ORAE	Proportion of inpatient hospital encounters where patients have been administered an opioid medication outside of the operating room and are subsequently administered an opioid antagonist with 12 hours, an indication of an opioid-related adverse event
IMM-3	Healthcare workers given influenza vaccination
OP-18a	Average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility
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 the Care Compare on Medicare.gov website
OP-18d	Average (median) time transfer patients spent in the emergency department before being transferred to another facility
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
OP-40	Percentage of ED patients with a diagnosis of STEMI who received timely delivery of guideline-based reperfusion therapies appropriate for the care setting and delivered in the absence of contraindications
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
STK-02	Percentage of ischemic stroke patients prescribed or continuing to take antithrombotic therapy at hospital discharge
STK-03	Percentage of ischemic stroke patients with atrial fibrillation/flutter who are prescribed or continuing to take anticoagulation therapy at hospital discharge
STK-05	Percentage of ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2
VTE-1	Percentage of patients that received VTE prophylaxis after hospital admission or surgery
VTE-2	Percentage of patients that received VTE prophylaxis after being admitted to the intensive care unit (ICU)
Safe Use of Opioids	Percentage of patients who were prescribed 2 or more opioids or an opioid and benzodiazepine concurrently at discharge

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
Hybrid HWR	Hybrid Hospital-Wide All-Cause Readmission Rate
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

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

VA_TE.csv

Measure ID	Measure Name
EDV-1	Emergency Department (ED) Volume
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
OP-29	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy
SEP-1	Severe Sepsis and Septic Shock
STK-02	Discharged on Antithrombotic Therapy
VTE-1	Venous Thromboembolism Prophylaxis
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis

VA_IPF

Measure ID	Measure Name
HBIPS-2	Hours of physical restraint use
HBIPS-3	Hours of seclusion
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

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 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 the Care Compare on Medicare.gov website
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
CCN	
ASC CCN	The first two digits identify the state, followed by the letter "C", three zero's, and the last four digits identifying the ASC facility
Facility ID (CCN for non ASC facilities)	The CCN for providers and suppliers paid under Medicare Part A have six digits. The first two digits identify the State in which the provider is located. The last four digits identify the type of facility

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.	This footnote is applied: • 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 a healthcare facility 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.	This footnote indicates that the healthcare facility 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. This footnote is applied: • When a healthcare facility 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 healthcare facility 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.	This footnote is applied: • When a healthcare facility elected not to submit data for the entire reporting period; or • When a healthcare facility had no claims data for a particular measure; or • When a healthcare facility elected to suppress a measure from being publicly reported.
6	Fewer than 100 patients completed the CAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess facility performance.	This footnote is applied when the number of completed surveys the facility 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.	This footnote is applied when: • Too few healthcare facilities 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 CAHPS 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 facility performance.	This footnote is applied when the number of completed surveys the facility 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.
12	This measure does not apply to this hospital for this reporting period.	This footnote is applied when: • 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: • 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 healthcare facility or its vendor provided to CMS is less than 100. To get CAHPS Star Ratings, healthcare facilities must have at least 100 completed CAHPS 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: • 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 Department of Defense (DoD) hospitals.	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. This footnote is no longer used.
28	The results are based on the hospital or facility's data submissions. CMS approved the hospital or facility's Extraordinary Circumstances Exception request suggesting that results may be impacted.	This footnote is applied when a hospital or facility alerts CMS of a possible concern with data used to calculate the results of this measure via an approved Extraordinary Circumstances Exception form. Calculated values should be used with caution.
29	This measure was calculated using partial performance period data due to a CMS-approved exception.	This footnote indicates that the hospital's results were based on data reported for less than the maximum possible time period used to collect data for a measure but not all quarters. This footnote is applied when CMS has approved an Extraordinary Circumstances Exception for one or more quarters of data used to calculate the results of this measure.
Maryland data foonotes		
*	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

Public Reporting Footnote Values		
#	**Text**	**Definition**
**	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
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

October 2025 Release

- CMS is publicly reporting results for the following measures for the first time in the October 2025 PDC release: GMCS, GMCS: Malnutrition Screen, GMCS: Malnutrition Diagnosis Documented, GMCS: Nutrition Assessment, GMCS: Nutrition Care Plan and HH-ORAE.
    - The CY 2024 rates for GMCS were determined to be erroneous due to the known issue with the CY 2024 measure specifications. As a result, CMS will not publicly report the rates for providers who voluntarily submitted this measure. The measure rates will instead display "Not Available" or "N/A" with footnote 4, "Data suppressed by CMS for one or more quarters."
    - For additional information: https://oncprojectracking.healthit.gov/support/browse/EKI-21
- CMS is publicly reporting results for OP-18a, OP-18d, REH-OP-18a, REH-OP-18b, REH-OP18c, and REH-OP-18d with the October 2025 release for Hospital Outpatient Quality Reporting (OQR) eligible discharges.
- CMS is publicly reporting results of the Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS) Survey for hospital outpatient departments on the Care Compare website beginning with October 2025 release for Hospital Outpatient Quality Reporting (OQR).
- CMS retired data collection for the following measures: ASC-20, HCHE, ED-2-Strata-1, ED-2-Strata-2, STK-06, and PC-05. Beginning with the October 2025 release, these measures have been removed from reporting.
- CMS will no longer publicly report HCP-COVID-19 for the Hospital Outpatient Quality Reporting and Veterans' Health Administration programs beginning with the October 2025 data release.
- CMS has updated the measure IDs for the following Hospital Inpatient Quality Reporting (IQR) measures beginning with the October 2025 release:
    - Hospital Harm - Severe Hyperglycemia, measure ID changed from HH-02 to HH-HYPER
    - Hospital Harm - Severe Hypoglycemia, measure ID changed from HH-01 to HH-HYPO
    - Cesarean Birth, measure ID changed from ePC-02 to PC-02
    - Severe Obstetric Complications, measure id changed from ePC-07a to PC-07a
    - Severe Obstetric Complications without blood transfusions, measure id changed from ePC-07b to PC-07b
- CMS was notified by some hospitals that the results for PC-02 and PC-07 were either much higher or lower than expected. After initial analysis, it was determined that a number of hospitals had mapping issues specific to outcome events and inclusion of pre-existing conditions within the QRDA submission. Given these issues, CMS is not publicly reporting CY 2024 results for these two measures.

The following updates can be found on QualityNet.cms.gov in the "Quick Reference Guides" located in the "Public Reporting" section.

- 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
- ASC Hospital Compare Preview Report Quick Reference Guide
- Inpatient Psychiatric Facility Public Reporting Quick Reference Guide

New dataset

Rural Emergency Hospital Timely and Effective Care	
Measure ID	**Measure Description**
REH-OP-18a	Average (median) time all patients spent in the emergency department before leaving from the visit including psychiatric/mental health patients and patients who were transferred to another facility
REH-OP-18b	Average (median) time patients spent in the emergency department before leaving from the visit excluding patients transferred to another facility or psychiatric/mental health patients
REH-OP-18c	Average (median) time psychiatric/mental health patients spent in the emergency department before leaving from the visit
REH-OP-18d	Average (median) time transfer patients spent in the emergency department before being transferred to another facility

New measures

Measure ID	Measure Description
Timely and Effective Care	
GMCS	Global Malnutrition Composite Score
GMCS: Malnutrition Screening	Percentage of patients admitted to an inpatient hospital who have malnutrition screening documented in the medical record
GMCS: Malnutrition Diagnosis Documented	Percentage of patients admitted to an inpatient hospital with findings of malnutrition, upon completing a nutrition assessment, who have a diagnosis of malnutrition documented in the medical record
GMCS: Nutrition Assessment	Percentage of patients admitted to an inpatient hospital and were identified as at-risk for malnutrition upon completing a malnutrition screening who have a nutrition assessment document in the medical record
GMCS: Nutrition Care Plan	Percentage of patients admitted to an inpatient hospital with finding of malnutrition, upon completing a nutrition assessment, who have a nutrition care plan documented in the medical record
HH-ORAE	Proportion of inpatient hospital encounters where patients have been administered an opioid medication outside of the operating room and are subsequently administered an opioid antagonist with 12 hours, an indication of an opioid-related adverse event
OP-18a	Average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility
OP-18d	Average (median) time transfer patients spent in the emergency department before being transferred to another facility

Removed measures

Measure ID	Measure Description
ASC	
ASC-20	Percentage of healthcare personnel who are up to date with COVID-19 vaccinations
Health Equity	
HCHE	The number of areas (0-5) that the hospital used to measure their hospital commitment to health equity
Maternal Health	
PC-05	Percentage of newborns that were exclusively fed breast milk during the entire hospitalization.
OAS CAHPS	
OAS CAHPS Survey Footnotes	Look up table for footnote summary text for OAS files (OAS CAHPS will now reference the Footnote Crosswalk).
Timely and Effective Care	
ED-2-Strata-1	Average (median) admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status
ED-2-Strata-2	Average (median) admit decision time to time of departure from the emergency department for emergency department psychiatric or other mental health patients admitted to inpatient status
STK-06	Percentage of ischemic stroke patients who are prescribed or continuing to take statin medication at hospital discharge
HCP COVID-19	Percentage of healthcare personnel who are up to date with COVID-19 vaccinations
VHA Timely and Effective Care	
STK-06	Percentage of ischemic stroke patients who are prescribed or continuing to take statin medication at hospital discharge
HCP COVID-19	Percentage of healthcare personnel who are up to date with COVID-19 vaccinations

July 2025 Release

- CMS is publicly reporting results for the Hybrid HWM measure for the first time with the July 2025 Care Compare release for Hospital Inpatient Quality Reporting (IQR) eligible discharges from July 1, 2023 – June 30, 2024.
- CMS updated the measure name from READM-30-HOSP-WIDE to Hybrid HWR.
- CMS is reporting the overall response rate and hospital participation in the voluntary reporting of the THA/TKA PRO-PM in the July 2025 release.
- CMS retired data collection for the following measures: PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE, and the Value of Care measure that utilized the payment measures in their calculation. Beginning with the July 2025 release, these measures were removed from reporting.
- CMS updated the Overall Hospital Quality Star Ratings as part of the July 2025 release.

The following updates can be found on QualityNet.cms.gov in the "Quick Reference Guides" located in the "Public Reporting" section.

- 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
- ASC Hospital Compare Preview Report Quick Reference Guide
- Inpatient Psychiatric Facility Public Reporting Quick Reference Guide

New dataset

Data Element	Description
Hybrid HWM	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate

Removed measures

Measure ID	Measure Description
IPFQR	
IPFQR-HCP COVID-19	Patients discharged from an inpatient psychiatric facility on two or more antipsychotic medications (medications to prevent individuals from experiencing hallucinations, delusions, extreme mood swings, or other issues), and whose multiple prescriptions were clinically appropriate
Payment and Value of Care	
PAYM-30-AMI	Payment for heart attack patients
PAYM-30-HF	Payment for heart failure patients
PAYM-30-PM	Payment for pneumonia patients
PAYM-90-HIP-KNEE	Payment for hip/knee replacement patients

April 2025 Release

- CMS has paused the public display of Hospital Promoting Interoperability Electronic Health Record (EHR) on the Care Compare tool on Medicare.gov. The Promoting Interoperability data is not currently available on the Care Compare tool on Medicare.gov. The Provider Data Catalog website has limited data reported for Promoting Interoperability within the new Promoting Interoperability dataset, such as the CEHRT ID (Certified Electronic Health Record Technology (CEHRT) ID). CMS will continue to communicate system updates.

The following updates can be found on QualityNet.cms.gov in the "Quick Reference Guides" located in the "Public Reporting" section.

- 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
- ASC Hospital Compare Preview Report Quick Reference Guide
- Inpatient Psychiatric Facility Public Reporting Quick Reference Guide

January 2025 Release

- The Centers for Medicare and Medicaid Services (CMS) has paused the public display of Hospital Promoting Interoperability Electronic Health Record (EHR) icon on the Care Compare tool on Medicare.gov. The Promoting Interoperability data is not currently available on the Care Compare tool on Medicare.gov. The Provider Data Catalog website has limited data reported for Promoting Interoperability within the new Promoting Interoperability dataset, such as the Certified Electronic Health Record Technology (CEHRT) ID. CMS will continue to communicate system updates.
- CMS retired data collection for PC-01, TOB-2, TOB-2a and HBIPS-5 beginning with CY 2023. Beginning with the January 2025 release, these measures have been removed from public reporting.
- The FY 2025 Hospital- Acquired Condition (HAC) Reduction Program results, including Total HAC Scores, are now available as part of the January 2025 release.
- The FY 2025 Hospital Readmissions Reduction Program (HRRP) results, including excess readmission ratios for each of the six 30-day risk-standardized unplanned readmission measures, are now available as part of the January 2025 release.
- The FY 2025 Hospital Value-Based Purchasing (VBP) Program Total Performance Scores and domain scores are now available as part of the January 2025 release.
- Added Footnote 29 to account for partial performance periods due to CMS approved exceptions.

The following updates can be found on QualityNet.cms.gov in the "Quick Reference Guides" located in the "Public Reporting" section.

- Inpatient Hospital Compare Preview Quick Reference Guide
- Medicare Promoting Interoperability Program Public Reporting 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
- ASC Hospital Compare Preview Report Quick Reference Guide
- Inpatient Psychiatric Facility Public Reporting Quick Reference Guide

New dataset

Promoting Interoperability-Hospitals	
Data Element	**Description**
CEHRT ID	Facility's Certified Electronic Health Record Technology identifier
Meets criteria for promoting interoperability of EHRs	Indicator for whether the hospital meets the criteria for the Medicare Promoting Interoperability Program

Removed measures

Measure ID	Measure Description
IPFQR	
HBIPS-5	Patients discharged from an inpatient psychiatric facility on two or more antipsychotic medications (medications to prevent individuals from experiencing hallucinations, delusions, extreme mood swings, or other issues), and whose multiple prescriptions were clinically appropriate
TOB-2	Patients who use tobacco and who received or refused counseling to quit AND received or refused medications to help them quit tobacco or had a reason for not receiving medication during their hospital stay
TOB-2a	Patients who use tobacco and who received counseling to quit AND received medications to help them quit tobacco or had a reason for not receiving medication during their hospital stay
IQR	
PC-01	Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary
DoD	
PC-01	Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary
VHA	
TOB-2	Patients who use tobacco and who received or refused counseling to quit AND received or refused medications to help them quit tobacco or had a reason for not receiving medication during their hospital stay